11-01694 Colin Emanuel Stuar	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death	08001
	Reg. No. 1. Decodor's Name (First Middle Last) 2. Date of Death 3. Till	me of Death
Medical Examiner	I Month Day Year I o	124 hrs
A .	Doctors Hospital Lanham Prince George's	na (State or
Funeral Director	Foreign	aryland
y and	Maryland Prince George's Greenbelt	Inside City Limits XYes 2 No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Lakeside Drive 20770 United State	es
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1	ndian, Black,
5-0036 ed within 72 hours a greater than the Medical Exami Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NONE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE	try
215-00 be filed with the Merit of the Merit	17. Father's Name (First, Middle, Last) Steven Matthew Stuart 18. Mother's Name (First, Middle, Maiden Surname) Ellen Thornbury Bastio	
MD 21 2 should th and Mer 27 is man	19a. Informant's Name/Relationship (Type, Print) Steven Matthew Stuart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 121 Lakeside Drive Greenbelt, Maryland 20	//0
nore, lages land of Heal and tricem of Heal of Heal of Heal of the other transcorpers.	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory of other place) Metropolitan Crematory 3/3/2011 20c. Location - City or Town Alexandria,	
	21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee Dollard Address Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Mary	land20705
Physician /Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden Infant Death Syndrome	proximate Interval etween Onset and Death
<u> </u>	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	_
executed an and al - transit ical Examiner	cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of):	-
be executed ician and urial - transi	M UNPENDED 23a,27 per me g915 5-2-11 vt	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 23d. Date of delivery Month Day	Year
ords, P.O. we requires that the as been signed by t should be detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contribution of the contrib	ause of death?
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Vital I hysician: this certifi ul director,	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Other Nursing Home 5 Residence 6 Other:	
ion of \ tending Ph eath. tor: After th the funeral	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Division o spital or Attending tours after death. neral Director After filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Could not be determined Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Roor Town, State)	oute Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire Completely filled in b	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	
M F S H S M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, L. March 3, 2011	Oay, Year)
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician/ 9:10 2011 Α Shank March Patricia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 320 S. Burhans Blvd. East Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, April 22, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 ■ F 74 214-36-0684 Maryland Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location notified at Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 320 S. Burhans Blvd. East 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S the Medical Examiner Black, White, etc. Armed Forces 1 Never Married 2 Married þ ☐ Yes 2 No 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Domestic traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F 2 Ernest Porterfield Jordan Nina Irene Goetz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr James W. Shank / Spouse Burhans Blvd. East, Hagerstown, MD 21740 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/9/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 5. Much Ju Hagerstown, MD 21742 1601 Pennsylvania Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ metastati Medical resulting in death) Due to (or as a consequence of) Examiner Canca uterme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🔲 Yes 2[™] No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 🗌 Yes 2-K No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work?
1 Yes 2 No Natural iniury 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

P.O. Records. **Division of Vital** filled in by the 24 hours after deat Funeral Director: within 24 ho

To the Fune

completed fi

046940 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 342 2216 Freme 32. Registrar's Signature

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Year)

4

TEL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Description of the cause of the post of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	lease				Depa	idelible In l artment of F <i>tificate of L</i>	lealth		Mental Hy	giene	Legible		
Physicia	in/	1. Decedent's Name (First, N		,				imedie of E	Jean		2. Date of Dea	Day	Year	3. Time of Death 8:28 p ^M	
Medic Examin		Verlin Harr 4a. Facility Name (if not instit	ution, give s		nber)			4b. City, Town, o		of Death	Februa1	4c. C	County of Dea	th	
Funeral Director		17937 Oak Ridge Drive 5. Social Security Number 217-16-2809 6. Sex 14 M 2 F 7. Age (In yrs. last birthde					rthday) Yrs.	If Under 1 Year Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Birl Sept 2	th	Washington 9. Birthplace (State or Foreign 1914 Marylland		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Deceder 10a. State 10b. Co Maryland Wa		ton		. City, Tov								10d. Inside City Limits 1 Yes 2 No	
	Funeral Di	10e. Street and Number 17937 Oak Ri				110	I40 V	10f. Zip Code 21740	ii- 0	:-i-0 (C-	seif. Von as No	USA			
ırs after dea ıral", or itei I Examiner	by	11. Marital Status 1 ☐ Never Married 2 🛭 3 ☐ Widowed 4 ☐ Divo	Married	12. Was Dece Armed For 1 X Yes If Yes, Giv Year or Da	rces? 2 No V e		11	Vas Decedent of H f Yes, specify Cuba	an, Mexica	n, Puerto	Rican, etc.)		4. Race - Ame Black, Whit pecify: Wh		
ithin 72 hou ene. • than "natu the Medical	Completed			lucation de completed) College (1	-4 or 5+)	-	(Give I life. D	lent's Usual Occup kind of work done O NOT use retired) Jisor	during mos	st of worki	ing		d of Business ation	Industry	
d be filed w Mental Hygis arked other itic event, t	To Be (17. Father's Name (First, Mid Harry Newto		alts_			.pcz	1502	18. Moth		e (First, Middle,	Maiden Su			
ind 2 should lealth and N im 27 is ma her trauma		19a. Informant's Name/Rela David Smalts		pe, Print) on)		3	311 (ng Address (Street Dak Manor		Apt	103 Gl	en Bu	rnie,	MD 21061	
it. Page 1 a intment of H intant: If ite njury or ot		20a. Method of Disposition 1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ot 21. Signature of Funcial Sen	her (Specify)	State	cemet	ery, cren Have	sition (Name of natory or other place) Cemete	ry	Mar 2	Date 2,2011	Hage		, Maryland	
Depa Impo any i		23a. Part 1. Enter the disease	se, or comp	lications that of		death. Do	4.		Cono	cocne	eague Si	c. W1	l Home lliams	Approximate	
Physician/ Medical		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only on	a Pulmo	onary or as a con:	Hype sequence	erter	nsion						Interval Between Onset and Death 1 Year	
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury b. Aortic Stenosis Due to (or as a consequence of): Mitral Insufficiency													
be executed sician and burial-transi	ल	that initiated events resulting in death) Last	l	C	or as a con:			icy							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, out	Birth 2 nant at time	Fetal dea		Ectopic pregnand Other (specify)	су			2:	3d. Date of do	elivery Day Year	
uires that th n signed by uld be detac	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Essential Hypertension 23e. Did tobacco use contribute to													
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Physician: r this certific aral director,	To Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death	_	28a. Date	of injury	28b.	Outpatier Time of	nt 3 🗆 DOA Oth	er: 4 🗆 N	lursing Ho	k only one) ome 5 🛱 Resid 28d. Describe h		•	cify)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	2 Accident In 3 Suicide 6 C	ending vestigation ould not be etermined	28e. Place	of Injury - Ang, etc. (Spe	At home, f	injury farm, stre	worl	⟨? Yes 2 □	□No		Street and		ural Route Number,	
he Hospita in 24 hours he Funeral pleted filled	Medical	(Check 2 DMed	ical Examir	ner: On the bas	sis of examin	ation and	or invest	occured at the time tigation, in my opini death occurred at th	on, death o	occurred at	t the time, date a	and place, a	and due to the	cause(s) and manner stated	
Nith Con E		29b. Signature and title of ce		un .	16).			29c. Licens D2381					signed (Mon		
4-10-1		30. Name and address of pe		354 M:	ill St	reet			Mar	yland	21740				
Sta Registr	ar	31. Date filed (Month, Day, Yo	0 2 20)11 32.7	gistrar's Si	ignature	1	all							
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 6:59 pM Feb_ 23, 2011 <u>Janice Roberta Schrey</u> Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Frederick <u>Prince</u> <u> Calvert Memorial Hospital</u> 9. Birthplace (State or Foreign Country) 8. Date of Birth ge (In yrs. last birthday) **Funeral** (Month, Day, Year) / 21 / 1936 1 □ M 2 🛛 F Months Director 138-28-1180 75 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🏋 Yes 2 □ No MD North Beach Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20714 USA 9312 Sea Oat Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Yes 2 No ş 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Insurance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Thomas Samual Robert Zulker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sharment of Health a tant: If item 27 is jury or other trains Cindy Mehrtens/Daughter 9312 Sea Oat Ct., North Beach, MD 20714 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important; If any injury or 2/28/11 Beltsvile, MD Chesapeake Crem. Signature of Funeral Service Lio nsee 22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final embolesmi Ph sician/ palmonery disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ston con Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on. or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a 1 ☐ Yes 2 ¾ g ☐ Unknown a 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by desease 1 Yes 2 No 3 Probably 4 No Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 s autopsy death? perform 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work?
1 Yes 2 No 1 X Natural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 20061783 2011 , MO 10 KW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Chang Choi 100 the spital Road, Prince Frederick, MD

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

100

31. Date filed (Month, Day, Year)

FEB 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		rtment of H tificate of D			iene 2011	08005
	Physicia		1. Decedent's Name (First, Middle, Kelem wa	_{Last)} Teffera			_		2. Date of Dear Month Februar	y 22, 2011	3. Time of Death 1:25а м
	Medic Examin		4a. Facility Name (if not institution, the Holy Cross Ho		eer)		4b. City, Town, or	Location of Death	ıg	4c. County of Deat Montgom	
	Funeral Director		5. Social Security Number 216-25-4203 Usual Residence of Decedent	3. Sex 1 □ M 2 🕱 F	'. Age (In yrs. la	ast birthday) 40 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birl 0, 1970	hplace (State or Foreign untry) Ethiopia
	aryland ta-f show fried at	ector	10a, State M D 10b. County M ont	y, Town or Loc	Silver	Spring		10d. Inside City Limits 1 ⊠ Yes 2 □ N			
	with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number 13239 Cop	land Cour	 t		10f. Zip Code 20	904		10g. Citizen of What Co United Stat	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental tygiene. Ked othygiene. Ked other than "natural", or items 23a or 28a-f show tie event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Seconday (0-12)	If Yes, Give Year or Dat 's Education	es? 2 No es.	16a. Deced (Give k	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 ☑ No ent's Usual Occupating of work done do NOT use retired)	Specify: ation uring most of work	king	16b. Kind of Business	e, etc. Lack Industry
and 21	be filed withi ental Hygien ked other th c event, the	To Be Co	17. Father's Name (First, Middle, La Teffera W.	st)	· · ·	Certif	ied Nursir	18. Mother's Nam	ne (First, Middle, Pede T. T		au
	of and 2 should be file of Health and Mental F fitem 27 is marked of rother traumatic ever		19a. Informant's Name/Relationshi		sband	19b. Mailin				City or Town, State, Zippring, Mary	
Baltimore,	Page 1 an ment of He ant: If iten ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		Stata C	emetery, cren ck Cre	sition (Name of natory or other place ek Cemet	ery Feb			on DC
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lindre	houpso	w/					uneral Servi Washington	
1	nysician/ Medical		23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	lly one cause on eac End-	h line. Stage	Gastri	r the mode of dying	g, such as cardiac	or respiratory arre		Approximate Interval Between Onset and Death
	Examiner	je.	Malignant Ascites								months
	ie be executed ysician and he burial-tr.nsit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last								
. Box 68760	death certificat ne attending ph ed for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		Birth 2 ☐ Feta ant at time of o	aldeath 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
s, P.O.	ires that t signed b d be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								the cause of death?
Division of Vital Records,	sician: The law requires that the certificate has been signed by the irector, page 2 should be detach	Completed							24a. Was a autop perfor	sy prior to med? death?	ntopsy findings available completion of cause of
/ital	sician:	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒️No	Hospital:	npatient 2	EB/Outpatier	Othe	er:		ence 6 Other (Spec	rifu)
on of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certification properties of the funeral director, completed filled in by the funeral director,	Certificate: T	27. Manner of Death 1 Anatural 5 Pending 2 Accident Investig	28a. Date of (Monting)		28b. Time of injury	28c. Injury work	/ at		ow injury occurred	ary)
Division	ial or Atte s after de al Directo ed in by th		3 Suicide 6 Could r 4 Homicide determi	28e. Place	of Injury - At ho g, etc. (Specify		eet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	iral Route Number,
_	the Hospit nin 24 hour the Funera	Medical	(Check 2 Medical Exonly one) 3 Certifying	caminer: On the basi	s of examination	n and/or invest	tigation, in my opinic death occurred at the	on, death occurred a e time, date and pla	at the time, date and due to the	cause(s) and manner as	cause(s) and manner stated. stated.
	Vith Vith To I		29b. Signature and title of certifier Barbara /	Supania	ch, RSN	4MD	29c. License	number 065 485		29d. Date signed (Mont	
			30. Name and address of person v Barbara Supa	ho completed cause	of death (Item						
	Sta Registr		31. Date filed (Month, Day, Year)	A 2. Re	glstrar's Signa	ture	se .				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 19, 2011 Year **Physician** 4:15 A M Elise Treadway Joanne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Patuxent River Nursing and Rehab Center Laurel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months April 17, Washington, DC Director 220-34-2753 71 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the two deal Event in that by notified at 1 ☐ Yes 2 TNo Directo Marvland Prince Georges Laurel Pages 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20707 15610 Bounds Avenue Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ∏Yes 2 X No fYes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Completed by 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bank Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Tierney Vernon Iseli ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15610 Bounds Avenue, Laurel, Maryland 20707 Brenda Kearns-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o ō X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 2/25/2011 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fleck Funeral Home, INC.
7601 Sandy Spring Rd., Laurel, MD 20707 21. Signature of Fune Service Licenses MO Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 07 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Onknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: nours after death.

neral Director: After this ce
y filled in by the funeral direc 1∐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a i 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funel

completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ည 20

State Registrar

30. Name and address of person who completed cause

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Medical Virginia Terrel1 March 6:15 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown Mary's . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 0. Date of Birth (Month, Day, Year) 02/23/1917 1 □ M 2X F Months Days Hours Min. Director 579-10-2565 94 Marvland Usual Residence of Decedent show or 28a-f shov notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland St. Mary's 1 Yes 2 No Mechanicsville 10e. Street and Number ö 10f. Zin Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be by Funeral 39468 Golden Beach Rd. 20659 S Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Percy Weisiger Gay Estelle Hancock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Terrell/Son 39468 Golden Beach Red., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) Veterans Cem: 03/10/2011 Cheltenham, Maryland 22. Name and Address of Facility Brinsfield-Echols Funeral Home, Maryland Veterans Cem 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ disease or condition inutes Medical resulting in death) as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month ☐ Pregnant at time of death☐ Unknown Day Year 9 Unknow The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 7 Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examiner? 1 Yes Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 24 hours after death. Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) ichae State 31. Date filed (Month, Dav. Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month February 2.011 Physician/ 8:34 A M Joseph Gwynn Williams, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Harwood Mandrin Chesapeake Hospice House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth Funeral Days Months Hours 1 🖾 M 2 🗆 F July 28, 1927 Mary land 216-22-2559 Director 83 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. Count 10c. City, Town or Location 10a. State with the Maryland must be notified at Director 1 Yes 2 No St. Mary's <u>Mechanicsville</u> Maryland 10f. Zip Code 10g, Citizen of What Country? 0 10e Street and Number Funeral items 23a USA 20659 37525 Lockes Crossing Road death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. Examiner Armed Forces? Black, White, etc. and Mental Hygiene. by 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates the Medical 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Grain Elevator Elementary/Seconday (0-12) College (1-4 or 5+) Company Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Jane Burroughs Joseph Gwynn Williams, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Joseph Gwynn Williams, III / Son 311 B Poplar Avenue, Edgewater, MD 21037 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 2. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Queen of Peace Cemetery 2011 Helen, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 Kenneth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, Pancreatic cancex disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Uncertying Examine Due to (or as a consequence of) requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 X No Jas death? certificate l 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred Hospital or Attending Pl 124 hours after death.
 Funeral Director: After the Certificate: Natural Natural work 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0022102

Registrar

DHMH 17 Rev 7/2009

State

Drive

32. Registrar's Signature

lette HI MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARKET

7767

Day, Year)

31. Date filed (Month,

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	Physicia Medio	n/	1. Decedent's Name <i>(First, Middle</i>	_{e, Last)} i11ian	В.	Wi <u>l</u>	liams	son_		Month Februar	Day	2011	12:50 AM
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<u>√</u> √.			Manor Care Hea	11th Service	es Age (In yrs. Ia	and biode days	Tow		If Under 24 Hrs.	8. Date of Birt		timore	place (State or Foreign
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	death items ier m		11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S	S. 13. ¹	Was Dece	dent of Hisp cify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
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21215-0036	be filed within 72 hours after death with the Maryland and the Hygiene 728 or 288-f sho ked other than "natural", or items 238 or 288-f sho ked other than "natural", or items 238 or 288-f sho ite event, the Medical Examiner must be notified at		Elementary/Seconday (0-12)	2	51 5+)	Homen	naker				Own 1	Home	
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yla	lid be Ment narke	욘	James Bernard 1			12		_	Gerda Bo				
Maryland	is 1 and 2 should be file of Health and Mental H fitem 27 is marked of r other traumatic ever		19a. Informant's Name/Relations		1.				d Number or Rur				
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noi	age 1 ent of nt: If if y or c		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other (ale	emetery, crei	-		Cre03/05	5/2011	Charl	otte Ha	11 MD
Baltimore,	permit. Page 1 s Department of H Important: If ite any injury or ot		21 Si satura di Pineral Sérvice	Tensee) IPII				of Facility Bri				
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P.O.	that the		Part II. Other significant condit	ions contributing to deat	th but not res	sulting in the	underlying	g cause give	n in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
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siol	Attendration deat	Certificate:	3 Suicide 6 Coule	28e, Place of	Injury - At h	ome, farm, st						lumber or Rura	l Route Number,
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_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Chook 2 Modical	ng Physician: To the bes	of examination	on and/or inve	stigation, i	n my opinior	 death occurred : 	at the time, date :	and place, ar	nd due to the ca	ause(s) and manner stated.
	the lathin 2 the l	Ž	only one) 3 Certifyir 29b. Signature and title of certifi	ng Nurse Practioner: To	the best of m	ny knowledge,		ourred at the 9c. License		ace, and due to th		signed (Month,	
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			30. Name and address of person	n who completed cause	of death (Iter	n 23a) (Type,	Print)		749 Noon,				
			30. Name and address of person		usler	77	100,	10	1 As 701 A	W 9	21:	2014	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ature	book	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-01711 State of Maryland / Department of Health and Mental Hygiene Ramsey Wyatt White 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1424 hrs March 2, 2011 **Medical Examiner** Ramsey Wyatt White

4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Foreign Hours Months CountryFlorida Director 21,1980 262-97-3022 30 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 Yes 2 No Florida Lake Mount Dora 28a-f shov or items 23a or 28a-f shor must be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 32757 ۵ 1736 Jefferson Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 * Never Married 2 Married 2 * No Yes Specify: Black 1 Yes 2 No specify: 4 Divorced If Yes, Give Year or Dates: 3 Widowed 2 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electronic Computer Engineer Baltimore, MD 21215-0036 4 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Jean White Raymond Tolbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code § 2757 19a. Informant's Name/Relationship (Type, Print) 1736 Jefferson Dr., Mount Dora Florida Dorothy J. White/Mother 20c. Location - City or Town, State 2011 2011 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 🛪 Burial 2 Cremation 3 Removal from State Mar.12th Mt. Dora Florida Pine Forest 4 Donation 5 Other Specify 22. Name and Address of Facility 3831 Georgia Avenue, N.W. 21. Signature of Funeral Service Licensée Washington, DC Latney's Funeral Home CC0278 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and failure. List only one cause on each line Death (Medical Diabetic Ketoacidosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and AMENDED 23a,27 per me g913 3-16-11 vt Physician/Medical X UNPENDED attending physician or use as the burial -Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery IF FEMALE Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death 2 past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 2 Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? this certificate has 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: examiner? 1 V Yes 2 No 28d. Describe how injury occurred 28b Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State 31. Date filed (Month, Day, Year) 2011
Registrar

Carol Allan, MD

0-6

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

av

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

March 3, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For AMEND#29D per PHY. State of Mar State 2/22/2011 AACO HEALIH DEPT. (yland CMH	/ Depa	rtment of H	lealth Death	and M	ental Hy	giene Reg. No.	0	08011
	Physicia		1. Decedent's Name (First, Middle, Last)						2. Date of Dea		Year 2011	3. Time of Death
	Medic	al .	Clara Wasserman 4a. Facility Name (if not institution, give street and number)			4b. City, Town, or	Location	of Death	/ t 5.	4c. C	County of Deat	h
_}	Examin		BALTIMORE WASHINGTON	mico	CTR	E LET	-i (2	BUR	MLE	Ar	4 ME F	ARUMBEL
	Funeral Director		5. Social Security Number $070-18-5315$ 6. Sex $1 \square \text{ M } 2 \stackrel{\text{Y}}{=} \text{ F } 86$	In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Birt 3/15/1			thplace (State or Foreign untry) WYork
	nd how at	. 1	Usual Residence of Decedent 10a. State 10b. County 1	I0c. City,	Town or Loc	ation						10d. Inside City Limits
	Aarylar 8a-f s tified	Director	Maryland Anne Arundel	Aı	nnapol	lis						1 🗆 Yes 2 🛣 No
	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Number 935 Ships Bell Ct.			10f. Zip Code 21	401				en of What Co SA	ountry?
030	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Event Armed Forces? 1 ☐ Yes 2 ☑ X Nife Yes, Give Year or Dates.			/as Decedent of Hi Yes, specify Cubar ☐ Yes 2 🔀 No			cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit pecify:	
9500-612	in 72 hours e. nan "natur Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)		(Give I life. D	ent's Usual Occupa ind of work done of NOT use retired)	ation luring mo	st of workir	ng	16b. Kin	d of Business	Industry
Z	d withi	Be Co	12th		Hor	nemaker T	10 Mot	harla Nama	(First, Middle,	Maidan Si	Home	
ano	be file ental F ked of	To B	17. Father's Name (First, Middle, Last) Jack Sedaca				16. MOL		nie Shu		arriarrie)	
Maryland	1 and 2 should be file if Health and Mental F item 27 is marked o other traumatic ever		19a. Informant's Name/Relationship (Type, Print)			g Address (Street a						
	1 and 2 s of Health item 27 other tra		Steve Wasserman/ Son	Look Pt.		Wordswor	th D				land 2 cation - City or	
nor	Page 1 anent of Hant of Hant: If ite		20a. Method of Disposition 1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cen	metery, cren	sition (Name of natory or other plac ematory	e))ate /11		-	Maryland
Baltimore,	permit. Page 1:8 Department of H Important: If ite any injury or of once.		21. Signatural Pervice Licensee	Kai	22	Name and Addres	s of Faci	lity Geo	rge P.	Kala	s Fune	ral Home
	THE TOTAL		23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.		Do not ente	r the mode of dyin	g, such a	s cardiac o	r respiratory ar	rest,	,	Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a disease)	conseque	(C) []	76 10	7 1-4-	ARC	1101			DAYS
	14.8	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a condition)	conseque	ence of):			_				
	e be executed ysician and e burial-transit	Examiner	Cause (Disease or iinjury that initiated events		nao ofi:							
	be executed sician and burial-transi	calE	resulting in death) Last Due to (or as a d	Jonseque	ince oi).							
19/89	ficate g phys as the		d									
Box 68	v requires that the death certificate is been signed by the attending physishould be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	Fetal o	death 3	Ectopic pregnand Other (specify)	у			2	3d. Date of de Month	elivery Day Year
<u>о</u>	that the	by Ph	Part II. Other significant conditions contributing to death but	t not resul	Iting in the u	nderlying cause giv	ven in Pa	rt I.				o the cause of death?
ds,	equires	eted										Probably 4 Unknown
Division of Vital Records,	The lav ate has page 2	Completed							24a. Was auto perfo 1 \(\sum \) Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of
<u>ta</u>	sician: The lar certificate ha irector, page 2	Be	25. Was case referred to medical examiner?			Oth	or	eath (Check				
) (y Phys er this eral dir	e: 일	1 Yes 2 No 1 Inpatier 27. Manner of Death 28a. Date of injury	/ 2	28b. Time of	28c. Injur	4 <u> </u>		me 5 Resi 28d. Describe			city)
ou	ending eath. or: Afte he fun	Certificate:	1 Natural 5 □ Pending (Month, Day, 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be		injury		Yes 2					
OIVIS	al or Att s after d l Direct d in by t		4 Homicide determined 28e. Place of Injurbuilding, etc.		ne, farm, str	eet, factory, office			28f. Location (City or To		Number or Ri	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of machine in the basis of examiner: On the basis of examiner: To the basis of examiner: To the basis of examiners in the basis of	amination :	and/or inves	tigation, in my opinie	on, death	occurred at	the time, date	and place.	and due to the	cause(s) and manner stated
	To the within To the complete	2	29b. Signature and title of certifier			29c. Licens	e number			29d. Date	e signed (Mon	th, Day, Year) 2/20/20
	1		30. Name and address of person who completed cause of de	ath (Item)	23a) (Type, I	Print)				1 6	, 20	
1	CH		GEORGE BAFFOE- BO	~~	cē,	301 110	SPIT	AL i	R. 40	CH	BURN	12 mg 2/01
	Sta Registra		31. Date filed (Month, Day, Year) September 32. Registrar	's Signatu	A. A	backer						ue mo 2100

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death 5, Day Physician/ March 201^Y1^{ar} 10:35A. M Edmund William White Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Renaissance Gardens at Riderwood Village Silver Spring If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Hours July 84, 1920 1 🔀 M 2 🗆 F 90 Pennsylvania 073-14-9209 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medital Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Maryland Prince George's 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 20904 Funeral 3142 Gracefield Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Arred Forces?
1 1 12 Yes 2 1 No
1f Yes, Give 10/1/1-10 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Specify res, Give Year or Dates. 1944–1946 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Chemical Engineer government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grace Faunce Edmund Britten White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zio Code). 3142 Gracefield Road Silver Spring, Maryland 20904 Nathalie White -wife 20a. Method of Disposition
1 ☐ Burial 2 🌡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Metropolitan Crematory 3/7/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Borrald Vores Borrawardt Funeral Home, PA Darald V15 en 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Year Immediate Cause (Final Pnysician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner weeks ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami b Hospital or Attending Physician. The law requires that the death certificate be executed 24 hours after death. Cerebrovascular Accident 2 weeks and -tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2**V** No Hospital Other: 1 🗌 Yes within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral directions. ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29q. Date signed (Month, Day, Year) 29c. License number 11263 a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CINP 3/160 Gracefield Road Silver Spring, Maryland 20904 Juliahe Harding, State Registrar

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DHMH 17 Rev 7/2009

01482		Please Type or Print in Black Indelible Inl	k. Ensure All Cor	oies Are Legible.	
orge Alexan		Valsh, III State of Maryland / Department of I	Health and Mental	Hygiene	2011 08013
Physic dical Exam	ian/ iner	1-For State AMEND#5 per FH/AMO HEATTH Certificate of L Registrar 3/2/2011 AA OD HEATTH DED OM CERTIFICATE OF L 1. Decedent's Name (First, Middle, Last) George A. Welsh III		Reg. No. 2. Date of Death Month Day February 22, 201	3. Time of Death
)		4a. Facility Name (if not institution, give street and number) 4b	. City, Town, or Location of De Crownsville	ath 4c. C	ounty of Death
Funeral		1007 BOCKSET DI.	If Under 1 Year If Under 24	Hrs. 8. Date of Birth(MM/DD	/YYYY) 9. Birthplace (State or
Director		212-52-3154 216-74-7263 Usual Residence of Decedent	Months Days Hours	Ain. 11/21/1949	Foreign Country) MD
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
faryland 28a-f show 1 at once	Director		sville 10f. Zip Code	10g, Citizen	1 Yes 2 No
th the Maryland 23a or 28a-f sho	Dire	1009 Dockser Dr.	21032		USA
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she item 27 is marked other than "natural" or items 23a or 28a-f she it fraumatic event, the Medical Examiner must be notified at once	Funeral		Decedent of Hispanic Origin? (, specify Cuban, Mexican, Pue		. Race - American Indian, Black, White, etc.
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5 72 hour in "natu	leted	Elementary/Secondary (0-12) College (1-4 or 5+) during most	Usual Occupation (Give kind of tof working life. DO NOT use		d of Business/Industry
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21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	George A. Welsh Jr.	Doris	Anne Snitzer	
and 2 should and 2 should fealth and Mitem 27 is m traumatic	To		uray Dr. Balti		
nore, MI ages I and 2 s ant of Health a at: If item 27		20a. Method of Disposition 1 Burial 22XX Cremation 3 Removal from State 20b. Place of Disposition crematory or other	on (Name of cemetery,		ation - City or Town, State
Baltimore permit. Pages 1 a Department of He Important: If it injury or other t		4 Donation 5 Other Specify: Atlantic C	rematory 2/	26/2011 Glen	Burnie, MD
		James K. Govoni per dvr 851	Annapolis Rd.	Gambrills,	MD 21054
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atheros			Between Onset and
xaminer		or condition resulting in death) Due to (or as a consequence of):.	CIEIOLIC CAIG	OVASCUIAL DIS	sease
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause b			
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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S876C rtificate ing phys as the b	cian/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	death 3 Ectopic preg	23d. D	ate of delivery nth Day Year
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P.O. Box 68760, that the death certificate be execut ned by the attending physician and detached for use as the burial - tra	Physi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the und	lerlying cause given in Part I.		contribute to the cause of death?
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Assistant Medical Examiner State 31. Date filed (Hopeth, Day, Year) Registrar

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature parker

900 W. Baltimore Street, Baltimore, MD 21223

11-01905 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Margaret O. Alston For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0915 hrs Medical Examiner Margare March 10, 2011 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death County of Oeath Baltimore 3705 Ferndale Avenue NI If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Min. Director Country) 244-56-547 Yrs. NC 1 M Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Nes 2 No 'natural", or items 23a or 28a-f shov Examiner must be notified at once. It more Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 1 Yes 3 Widowed 1 Yes 2 No specify: If Yes, Give Year 4 Divorced Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **MD 21215-0036** 2 should be filed within 72 h and Mental Hygiene. tant: If item 27 is marked other than " or other traumatic event, the Medical 2 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Bullock Baltimore, MD 212 permit. Pages 1 and 2 should be Department of Health and Ment 19a. Informent's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) to more, 20b. Place of Oisposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 2 Cremation 3 Removal from State alti more 4 Dopation 5 Other Specify 21. Signature of Funeral Service Lices urura Acre 400 glus Balto. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Oue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Oue to (or as a consequence of): Examine cause: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical K AMENDED #18,19a,perFH,G913,3/21/2011,WS signed by the attending physician of be detached for use as the burial UNPENDED P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth Day 3 Ectopic pregnancy Month Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown dementia Completed Division of Vital Records, After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 V No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) B examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA 2 ER/Outpatient 3 1 V Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A filled in by the f Pending 1 Yes 2 No 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number O.C.M.E. March 11, 2011 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Melissa D. Crowder Anderson burch 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balhmare City Hosoi la 9. Birthplace (State of Foreign Country) Date of Birth (Month, Day, Year) 8–12–1969 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months 1 □ M 2 🛛 F 41 219-04-8324 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1∩a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla peptriment of Health and Mental Hygient. Studies in the state of the studies and the state of the studies than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its file that Experimental permitted. 1 ☐ Yes 2 No Director Pikesville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 8815 Pikesville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 African-American 1 □Yes 🎾 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Direct Care Shift Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet Crowder Charles Brown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen K. McCarpo/Sister 8815 Pikesville Road, Pikesville, MD 21208 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 3-15-2011 Baltimore, MD 4 ☐ Donation ^{*}5 ☐ Other (Specify) 21. Signature of Funeral Service Licensel 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Port 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Minutes HOOKIA disease or condition resulting in death) /Medical (or as a consequence of): Examiner Pulmonary Disease Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi Asthma Due to (or as a consequence of): Pax toME/M Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Hyper knscon Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☑ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred P Hospital or Attending P 24 hours after death. Funeral Director: After t 1 Natural 5 Pending investigation 1 □Yes 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Sina filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

MAR 1 5 2011

hert Known As: Melissa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011 08016 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death 3 Time of Death Decedent's Name (First, Middle,Last) Physician/ Month 0730 hrs Yusuf Alim Medical Examiner March 12, 2011 Alini -Yusai 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death Maryland General Hospital NA8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Foreign PA Days Min Hours 04-24-50 Director 60 205-40-0571 1 X M 2 F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State Baltimore 1XXYes 2 No NA MD 28a-f show items 23a or 28a-f shorust be notified at ooce. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Importable If file 27 is marked other than "natural", or items 23s or 28s-f sho
injury or other traumatic event, the Medical Examiner must be notified at occe. Director 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number USA 21217 1803 McCulloh Street Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. White, etc. African If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes specify: American f Yes, Give Year or Dates: 1 Yes 2 No specify: 4 Divorced 3 Widowed 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Restaurant Cook 12th Grade 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 11 n K . unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4409 Maine Avenue Baltimore, MD 21207 19a. Informant's Name/Relationship (Type, Print) ۵ Samir Isail 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery. 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 03-14-11 Randallstown, MD King Mem. Pk. Donation 5 Other Specify: Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Medic Between Onset and failure. List only one cause on each line Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate couse: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Physician/Medical 1 per me g913 3-29-11 vt UNPENDED X AMENDED Hospital or Atteoding Physiciao: The law requires that the death certificate be 24 hours after death. Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Year 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Vunknown **Diabets Mellitus** Completed of Vital Records, this certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No Yes 2 ✔ No Yes 26. Place of Death (Check only one) 25 Was case referred to medical B examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: this 1 V Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After Certification: 1 V Natural Division within 24 hours after death.

To the Fuoeral Director: A completely filled in by the fu 1 Yes 2 No 5 Pending Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. March 14, 2011 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 2011 2:06 AM RUTH M. AXLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince **Examiner** George's Laurel Regional Hospita aure 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2**X** F Months Days Hours Min. 67 216-40-3000 Director 09/05/1943 Usual Residence of Decedent Prince George' permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Laurel MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20707 7700 Cherry Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Helathcare 12 Nurse Be Father's Name (First, Middle, Last)
Frances William Whinnie 18. Mother's Name (First, Middle, Maiden Surname) Anne Jean Koscho . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 579 S. 280 East, Orem, UT 84058 19a. Informant's Name/Relationship (Type, Print) 1579 Edward A. Axley Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 3/15/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Sepsis Ph_sician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown been signated by should by 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an cate has by page 2 s autopsy Chronic Obstructive Pulmonary eral Director; After this certificate hilled in by the funeral director, page Disease 2 No 2 XNo Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Accider
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and # 29d. Date signed (Month, Day, Year) D55861 March 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen

Registrar

DHMH 17 Rev 7/2009

State

Abdul Munim. MD

31. Date filed (Month, Day, Year)

Hospital

MD

Laurel Regional

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 3. Time of Death 4
12:55 M 2. Date of Death Physician/ Medical City, Town, or Location of Death **Examiner** last birthday) If Under 24 Hrs Age (**Funeral** Months **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anoe. 10d. Inside City Limits Director 1 Yes 2 No 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Race - American Indian, Marital Status Armed Forces' 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 No MARCH 13, 2011 12:55 a. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Decedent's Education (Specify only highest grade complete (Seconday (0-12) -4 or 5+) Be မ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) re of Funeral Service Licens nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Urknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 X No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural injury 5 Pending 1 Yes Accident Investigation 24 hours after death e Funeral Director. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21093 2300 DULANEY VALLEY RD. TIMONIUM, JUNECIA WHITE, CRNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 10^{ay} 20**1**T 1:10 p. M Arthur Brockington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a Baltimore 4114 Groveland Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) SC 9 (Month Bay, Year) 1x M 2 □ F Months Hours Min. 251-44-4730 79 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 4114 Groveland Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' þ 1 Never Married 2 X Married 1 Yes 2 No If Yas, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specifafrican-American Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shipping and Receiving Clerk Andrew's Air Force Base 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Arthur Brockington Victoria Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4114 Groveland Avenue, Baltimore, MD 21215</u> Finna G. Brockington/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 3-18-2011 Owings Mills, MD Garrison Forest Veterans Donation 5 Other (Specify) 22. Name and Address of Facility lie Funcial Home F.A. of baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ ucaus Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has to autopsv perform Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier Thavila cellisa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 828 N. EUTAW St. Balto 40 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signaty State Registrar

DHMH 17 Rev 7/2009

110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month/12/2011 Physician/ Year Sophie J. Bullock 11:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tate Hospice House Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8 Date of Birth **Funeral** Days (Month, Day, Yea, 8/4/1924 Min 1 M 2 X 219-12-3418 **Director** 86 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 USA 956 Long Cove Road death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 72 hours after 1 Yes If Yes, Give 2 💢 No Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Store Owner Sewing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Theodore Dobrodey Anastasia Soloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 956 Long Cove Road, Glen Burnie, Maryland 21060 Lisa Zimmerman / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State *Taponation 5 🕅 Other (Specify) Entombment Glen Haven Cemetery 3/15/2011 | Glen Burnie, MD Signature of Funeral Service Licens, e 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No signed by the atte Month Year Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 Yes 2 100 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A 2 Accident Investigation Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien 1 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 7:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore-Washington Med. Center Glen Burnie Arundel Anne If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 218-07-858 Maryland de Director shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No everna 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmitted. Elementary/Seconday (0-12) College (1-4 or 5+) 6 Storeroom Superintent Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ August Bova Santa Scollio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mel Bova / Son 506 Brentwood Avenue, Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State New Cathedral Ceme. 3/24/2011 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Strok disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate Cause (Disease or iinjury that initiated events Due to (or as a conseque-To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death signed by the a d be detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 4 Nursing Home 5 Residence 6 Other (Specify, eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after To the Funeral Dire Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Gettiying Prystrain. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10√ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8001 momeni 31. Date filed (Month, Day, Year) Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 043-09-2014 1330 George M. Bearman, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours Min. 01 1 Day 928 Country) MD 215-22-1691 83 **Director** Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at onee. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford MD Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21085 1309 Winding Valley Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces by 1 Never Married 2 Married ☐ Yes 2X No Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Should be filed within 72 h and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Domino's Sugar Supervisor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Ann Ruth George M. Bearman, Sr. tt. Page 1 and 2 should be rtment of Health and Mer rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joppa MD 21085 1311 Winding Valleys Dr Janet Self (daughter) permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens: 03-12-2011 Aberdeen, MD . Signator of Furer sprvice Licensee Schimunek Funeral Home of BelAir MacPhail Rd BelAir, MD 21014 MO0193 Inc 610 W. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ HOUTE MYGLARDIAL MEARCTION 484003 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant a 9 Unknown Pregnant at time of death 1 Yes 2 L completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autop performed 2 N autopsy 2 **X**No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

1330Pm

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D0056296 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person poer Chesapeake Dr. Bel Air, mo 21014

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 08023 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 2011 Dorothy I. Bailey 8:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House Montgomery Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🔀 F NOV 10 ^Y1922 New Jersey Director 147-12-4236 88 Usual Residence of Decedent show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4513 Windsor Lane 20814 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes Give Specify. 3 ₺ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic mans injury or other traumatic mans." Elementary/Seconday (0-12) 12 Secretary Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Wilby Verna B. Ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane B. Hipschman / Daughter 4513 Windsor Ln. Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 3/17/2011 Woodbine, Maryland Final Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Thyroid Cancer with metastases disease or condition vears resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph I for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year 1 ☐ Yes 2 € g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 K No certificate 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛭 Other (Specify)HOSPICE this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the F within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 03/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar G. Coleman

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

6001 Muncaster Mill Rd. Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 05 a Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death **Examiner** 4b. City, 1 Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, last birthday, If Under Birthplace (State or Foreign Country) **Funeral** Months **Director** Yrs. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director Yes 2 🗆 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced ac Year or Dates. 16a Decedent's Usual Occupation Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Houston 10 O 19a. Informant's Name/Relationship (Type, Print) 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 1/ 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr Approximate Interval Between shock, or heart failure. List only one cause on each line and Death Immediate Cause (Final dia Physician disease or condition resulting in death) Medical s a consequence of) Due to (or **Examiner** Sequentially list conditions, Examiner tary, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Mo Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? 2 -10 R/Outpatient 3 DOA Certificate: To 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 🗆 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cortifier 1158570

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

avcc

31. Date filed (Month, Day, Year)

601 Coch Reven

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ March 2011 5:30 Richard Albert Burton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Fulton 12007 Scaggsville Road 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Funeral 1**x**□ M 2 □ F Months Days Hours Min. (Month, Day, Year) April 3, Country) Maryland Director 80 220-26-4253 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No Howard Fulton o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12007 Scaggsville Road 20759 USA permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married ò 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No White Specify: "natural" 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 8th Brick Mason Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Minnie Maude Gaither Walter Thomas Burton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Robin Burton/Daughter Daring Prince Way, Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Union Cemetery 3/11/2011 Burtonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, 23a. Part 1. Enjer the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final

Melanoma Approximate Interval Between Onset and Death 28 Months Physician/ Melanoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? Yes 2 X No 2X No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2XXNo 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical 1 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m0

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

William H. Sharfman

D38409

10753 Falls Road, Suite 415, Lutherville, MD 21093

March 9, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gregory Jonathan Battle Month Physician/ March 11 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9002 Cheltenham Avenue Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min. (Month, Day, Year) Country) VA 1 **X**M 2 □ F 224-68-1106 61 Director Yrs 07/13/1949 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Prince George' Clinton 1X Yes 2 No 10e, Street and Number 10g. Citizen of What Country' USA Funeral 20735 9002 Cheltenham Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Bhack 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unkn. unkn. 12 Be 17. Father's Name (First, Middle, Last)
James S. Battle 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zio Code) 9002 Cheltenham Ave., Clinton, MD 20735 Jayne Battle / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 3/14/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorota Marshall 22. Name and Address of Facility arete Maryland Cremation Services 1Shoull 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) 7 Year Sth Pnysician/ Metastatic Colon Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ng physician and as the burial-transit Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 🛛 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident s after death completed filled in by the I Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier te signed (Month, Day, Year) March 11, 2011 MD 18126 Name and address of person Henry Fox, who campleted cause of death (Item 23a) (Type Print) inton, DC 20037

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Robert Bergschneider March 10° 201° 1° 7:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Towson Genesis Multi Medical Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 🛛 M 2 🗆 F 1/8/1947 Illinois **Director** 356-38-5766 64 iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 117 Stanmore Road 21212 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 X Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Cinematography 4 Cinematographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Irene Striegel Werner Bergschneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3777 Ivory Road Glenelg, Maryland 21737 Sandra Kenney / Companion 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 3/14/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson, Funeral Home, Inc. Signature of Juneral 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ NNG disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 🗌 No Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 2 No Certificate: To 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Suicide 1 Tes 2 🖵 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifie D0060 530 ompleted cause of death (Item 23a) (Type, Print) MHILADERHIA RD TERRIA 9106

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12:20 PM March George Franklin Bowens 201 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. N/A 5. Social Seculity Number Age (In yrs. last birthday) 8. Date of Birth 01/16/1943 9. Birthplace (State or Foreign **Funeral** Hours Days Months Maryland 212-42-5449 68 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Modical Examination to charting at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1XYes 2 No Director N/A Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 U.S.A. 605 Allendale Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No \$ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plummer 11th Grade Retired 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Franklin Bowens Margaret Fisher ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1320 Kenmore Ave., Fredericksburg, VA22401 Georon Bowens(son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/14/11 |Baltimore, MD Arbutus Cem. 21. Signature of Funeral Service Licensee Forephoders of Brown Jr. Funeral Home PA Magne MD21217 2140 N. Fulton Ave., Baltimore, 6 Approximate Interval Between Onset and Death **Physician** nknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 4 Unknown nertensov 1 ☐ Yes 2 ☐ No 3 ☐ Probably To the Hospital or Attending Physician: The law requi within 24 hours after death.

To the Funeral Director: After this certificate has been; completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only The) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3 DOA Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State Registrar

31. Date filed (Month, Day, Year) MAR 1 5 2011

Beneson

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29d. Date signed (Month, Day, Year)

900 Caton Avenue Hospital Bultimore Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For 08029 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 11:20 A M March Sean G. Cronin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9910 River Road Potomac Montgomery 8. Date of Birth (Month, Day, Aug 29 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 19<u>22</u> 1 XM 2 - F Ireland Director 88 339-28-9620 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Washington DC DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2500 Q Street NW #434 20007 Ireland within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Journalist Irish Times Newspaper Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ပ Cornelius (Con) Cronin Katherin Goggin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reva Rubenstein / Wife 2500 O St. NW #434 Washington DC, 20007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 03/14/2011 Woodbine, Maryland Final 21. Signature of Funeral Service Licensee, Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner cizuves Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate
Finter Inderlyin
Cause (Disease or iinjury HJdvarestalus use as the burial-transit 10ma YCSJUYC that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? for Pregnant at time of death Month Other (specify) be detached 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed should peen 24b. Were autopsy findings available 24a. Was an was an autopsy performed? or Attending Physician: The law prior to completion of cause of death? has page 2 2 No certificate 1 Tes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes YCVS ပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D HIIPT LUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doctori Dive Germantoun MD20874 19529

Registrar

DHMH 17 Rev 7/2009

State

NP-

MAR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 08030 State Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 P M March 8:48 Rene Carbo Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 20512 Top Ridge Dr. Boyds Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) 8 Date of Birth **Funeral** Days Hours Min May 30, 1939 1 🛛 M 2 □ F Ecuador Director 579-52-0702 71 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🄀 No Maryland Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20841-8920 United States 20512 Top Ridge Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🛣 Married 1 Yes 2 X No Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Specify: Hispanic/Latin 3 Widowed 4 Divorced Ecuadorian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Computer Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Plutarco Felipe Carbo Angela R. Leon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Carbo / Wife 20512 Top Ridge Dr. Boyds, MD 20841 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Final Journey Crematory 3/16/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licen ²², Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 der Wolte MO1251 Approximate Interval Between Onset and Death 22 years 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Kidney Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 🔀 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2X No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 은 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) To the Hospital
within 24 hours a
To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Jeph D32407 03/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, MD 9707 Medical Center Dr. Suite 300 Rockville, MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Havre De Grace Harford Memorial Hospital Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Hours 1 XM 2 □ I Director 216-76-3590 21 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 No MD Harford Havre De Grace 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö 239 Funeral 21078 U.S.A. 129 Vancherce Ct. ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after of ment of Health and Mentia Hyglene. The trians of surf if item 27 is marked other than "natural", or uny or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinum Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home lth grade Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Shirley Chew Alford Knox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Taylor-Mother 129 Vancherce Ct., Havre De Grace, Md 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 XBurial 2 Cremation 3 Removal from State King Memorial Park 3/19/2011 Woodlawn, Md Donation 5 Other (Specify) 21. Sign off Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of Jying, such as cardiac or respiratory arrest, shock, or heart cliure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequent **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be execute for use as the burlal-tran physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth
Pregnant a
Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of
injury
28c injury မ Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours a er death. e Funeral Director A Accident Investigation within 24 hours are death

To the Funeral Director, completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2 6 cause of death (Item 23a) (Type, Print) 12 O 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Theodore Chester Jr Month 7:30 A M 2011 Marci Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth (Month, Day, Yea **Funeral** 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. Birthplace (State or Foreign Country) Months **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 I If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 2 NO 1 🗆 Yes 2 XNo Specify: Black 3 Widowed 4 Divorced Completed Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Un Lown Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DIa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20c. Location - City or Town, State 3-15-2011 Kandallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Laryrogeal lancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ပု 1 Yes 2 No 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🗖 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number nsky uponeM.D 00057465 Ballimore, MD 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) apxKR, M.D 2835 5mim

State

Registrar

31. Date filed (Monti

32. Pagistrar's Signature

5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dorothy В. Cole 8:54 P M 20¹ March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4802 Ballygar Road Baltimore Nottingham 8. Date of Birth Septeth, Day Year 1922 Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 219-07-2459 1 M 2 XF 88 Director Usual Residence of Decedent 28a-f show 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Nottingham Maryland 1 Yes 2 XNo 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 9219 Carlisle Avenue 21236 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. "natural", or Completed by 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harvey Jett Pearl Machen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau John Cole 4802 Ballygar Rd., Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/14/2011 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Tar Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last physician the burial Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Dav Year 1 Yes 2X No signed by the a Unknown P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be irector, page 2 s autopsy performed' death? 2 X No 2 🗌 No 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2**X** No Other: 4 \square Nursing Home 5 \square Residence 6 $\sqrt[4]{}$ Other (Specify) Son's Home 1 Inpatient 2 ER/Outpatient 3 DOA pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 1 1 XNatural 2 Accident 3 Suicide 5 Pending after death. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State 24 hours a edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Underlied Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Underlied Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Underlied Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Underlied Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Underlied Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Underlied Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Underlied Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Underlied Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and date and place are determined at the cause of the ca within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Y

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gloria Berg Cochran 1:10 P M 2011 March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arcola Nursing & Rehab. Silver Spring Montgomery Center 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Year)
April 18,1924 9. Birthplace (State or Foreign Country) New York Funeral 7. Age (In yrs. last birthday, 1 - M 2 - F Min. Months Days 86 Director (Unk) Usual Residence of Decedent ral", or items 23a or 28a-f show Exam ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Arcola Ave. 20902 United States . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates the | edical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental H item 27 is marked of မ Theodore Berg Ethe1 Buzzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen C. Hirzy / Daughter 506 E St. NE, Washington D.C. 20002 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 💢 Cremation 3 🗆 Removal from State Chesapeake Crematory 3/11/2011 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Ser ²² Name and Address of Facility Rapp runeral and Cremation Services 933 Gist <u>Ave.</u> Silver Spring, MD M00382 le Dokum eur 20910 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAY Immediate Cause (Final disease or condition Physician/ PNEUMONIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical as the L IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 1 Yes 2 No detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 😾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 2 🖵 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 24 hours after death. Funeral Director: A 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [To the within 2 only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) D09834 MARCH 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 1 5 2011

68760

Box

P.O.

Records,

Division of Vital

20895

Barry N. Rosenbaum, M.D., 3720 Farragut Ave., Kensington, MD

32. Registrar's Signature

			Please Type or Print in Black I ITEM# 19a, per State of Maryland / Dep		All Copies A WS Mental Hygie	re Legible.	0005	
Ī	Physicia		Registrar 1. Decedent's Name (First, Middle, Last) Richard D. Carson	rtificate of Death	2. Date of Death	3.) 8 0 3 5 Time of Death 9:00A. M	
	Medic 1 Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice	4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore Co		
6	Funeral Director		5. Social Security Number 140–12–1035	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8, Date of Birth (Month, Day, Ye, Sept. 23,	9. Birthplace Country) Palmyr	a, N.J.	
	Aaryland 8a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le Maryland Baltimore County Timoniu				Inside City Limits	
	with the l s 23a or 2 ust be no	Funeral Di	10e. Street and Number 200 Belmont Forest Court Unit 405	10f. Zip Code 21093	10g	Citizen of What Country? United Sta		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Ir Black, White, etc. Specify: White	, i	
215-0	nin 72 hou ne. han "natu e Medica	Completed by	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	b. Kind of Business Industr		
ind 21	e filed with ital Hygier ed other t event, th	To Be C	12 04 I 17. Father's Name (First, Middle, Last) William Carson		ne (First, Middle, Maid	den Surname)	Crisciaccia	
Jaryle	should by and Mer is mark raumatic			ing Address (Street and Number or Run Belmont Forest Co	e Forder		,MD, 21093	
Baltimore, Maryland 21215-0036	age 1 and 2 sent of Health and 1: If item 27 in y or other tra	y i	20a. Method of Disposition 20b. Place of Disp	osition (Name of	Date 200	C. Location - City or Town (Harford Corest Hill, M	State Ounty)	
Balti	permit. F Departm Importa any inju			Alterialives I 2325 York Road Tin				
705	Ph_sician/ Medical Examiner pnual-transit	ical Examiner	23a. P.M. 1/ Enfer the disease, or comblications that caused the death. Do not enter shock, of heart follure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		or respiratory arrest,	Inte On:	proximate erval Between set and Death	
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23c. If yes, outcome of pregnancy 123b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day	y Year	
s, P.O	requires that the de been signed by the should be detached	d by Pl	Part II. Other significant conditions contributing to death but not resulting in the Dy Sphan's Sepsis won's le			co use contribute to the ca		
Record	rsician: The law requ s certificate has beer lirector, page 2 shou	Complete	consistive heavy fullung		24a. Was an autopsy performed 1 Yes 2	opsy prior to completion of cause of death?		
Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manne eath 1 Actural 5 Pending 2 (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 28b. Time of injury			e 6 Dotter (Specify)	Ho zyn co	
Division	al or Atte s after des Il Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Rou tate)	ite Number,	
_	he Hospih iin 24 hour he Funera ipleted fills	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner. On the basis of examination and/or inversionally one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	at the time, date and p	lace, and due to the cause(s	s) and manner stated.	
	To t virth		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day,	Year)	
	50~			es St Sukrues	Bulton	ove MD zu	204	
	Stat Registra		31. Date filed (Month, Day, Year) NAR 1 5 2011 32. Registrar's Signature	relat				

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decement's Name (First, Middle, Last). Month **Physician** 422AM ta 1ARCh 2011 /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes 5. Social Security 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Number **Funeral** Min Months Days Hours 1 □ M 2**X** F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location "natural", or items 23a or 28a-f shov Examiner must be notified at Funeral Director M.D1∭Wes 2∐No more 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21229 USA 206 Nonas 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ 3 Widowed 4 □ Divorced lack Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life: QO NOT use retired) is marked other than dary (0-12) College (1-4or 5+) omestic Be t and Number or Ryral Route Number 19b. Mailing Address Town, State, Zip Code) Nlillbank Ków MD 21044 olumbia 20b. Place of Disposition cemetery, cremator 20a. Method of Disposition Date Department of Important: If It any injury or o once. Burial 2 Cremation 3 Removal from State 6-2011 Baltimore, onl 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myscarch disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be execute physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 Other (specify) □Yes 2□No 9 Unknown þ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Vital 2 No 2 🗆 No 1 ☐ Yes To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1), 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Inv 2,229 BOCKWIN 3455 31. Date filed (Month, Day, Year) 32. R State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AVALLARD 0/30 OWIS Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AIR HARFORD SADEAKC If Under 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Davs Hours Min. Country) Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral I U-RIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me BALTIMORE Elementary/Seconday (0-12) College (1-4 or 5+) STADIUM MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PAVA//AM ၉ NYOINCHE OSARIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or WIFC Sidehil Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) BAHIMORE MATYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fineral Service Licensee 263 Part 1. Enter the dise e, or complications that caused shock, or heart fail e. Livit only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3

Ectopic pregnancy Month Day 5 Other (specify) Year 1 L Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the Hospital or Attending Physician: The law requires Ś 1 XYes 2 No 3 Probably 4 Unknown Record 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 Vital funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2**X** No 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending Division ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide within 24 hours a To the Funeral D Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ρ 3/13/2011 DOO 63220 GEORGE FIE SAP

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month. Day,

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Division of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Armelda Chevon Collins 027/26/2011 7:00a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville 4c. County of Death Examiner Montgomery Hospice Casey House Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 45 yrs If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 Days 169 to 34 49 65 Country) TI 342-68-2827 Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State MD 10d. Inside City Limits 10c. City, Town or Location Director Montgomery Gaithersburg 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18018 Royal Bonnet Circle 20886 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

14 Yes 2 No Prst
Year or Dates. Black, White, etc.
.. Black 1 Never Married 2 Married ģ 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5 +** Elementary/Seconday (0-12) Legalman Fírst Class U.S. Navy Be 17. Father's Name (First, Middle, Last)
Unavailable 18. Mother's Name (First, Middle, Maiden Surname, ည Jeanette Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernell W. Razor PR 7684 Collins Ridge Blvd Jacksonville FL3224 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place at lantic Crem 20c. Location - City or Town, State 02/27/2011 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilitSimplicity Crem & Fun Serv 21. Signature of Funeral Service Lice ThomasAllenPA 7090 RidgeRD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Ozet and Death Immediate Cause (Final Colon Cancer with Metastases Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? 1. ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death should be detached 9X Unknown 9 Unknown ģ Part II, **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XNo 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) Hospice 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 02/26/2011 Colacy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman 1355 Piccard Dr Suite 100 Rockville MD 20850 31. Date filed (Month, Day, Year) State MAR 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Day 12.48A M 0 March nca Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** tonsville Baltimore Nursing Home If Under 24 Hrs. Social Security Number 6 Sex 7 Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, -818 1 🗆 M 2 🖼 Days 70 Yrs. **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director must be notified 28a-f 1 Nes 2 No mas ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a -dmona filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: lack 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business Industry un (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LINK ၉ Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tamela Baltimore, MD briardia caltimize 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) +1M66 22. Name and Address of Facility Funeral Service Height. alto MD212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Failare Onset and Death Immediate Cause (Final Ph sician/ estive disease or condition resulting in death) Medical Due the r as a consequence of) **Examiner** ball Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit 50 9801 Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 To the Funeral Director, After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has k autopsy performe Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be (26. Place of Death (Check only one) Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 🖊 Nurs<u>ing Home 5 🗌 Residence 6 🗌 Other (Specify)</u> 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Am atun NICacem 30. Name and address of person who completed cause of death (Item 23a) (Type Print) MATUU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/

Reg. No.	08041
2. Date of Death	3. Time of Death

Medica Examine

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Meckeal Examiner must be notified at once. Baltimore, Maryland 21215-0036

> Physician/ Medical **Examiner**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Edward Herman Drude			M	arch 1	0, 2011	3:22 P M			
	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loca	tion of Death		4c. County of De	ath			
	848 Mago Vista Road		Arnold			Anne A	rundel			
		e (In yrs. last birthday)		nder 24 Hrs. 8	. Date of Birth		irthplace (State or Foreign			
	382-05-7415 1™ 2 □ F	93 Yrs.	Months Days Hou	urs Min.	Month, Day, Yearil 2, 19	217 M1	chigan			
	302-05-7415 93 113 ADM 2, 1917 MICI									
	10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits			
5		1 ☐ Yes 2 🔯 No								
	Maryland Anne Arundel Arnold									
	10e. Street and Number		10f. Zip Code		100	g. Citizen of What C	Country?			
5	848 Mago Vista Road		21012	?	Ţ	United St	ates			
3	11. Marital Status 1									
5										
3	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.1940–1960 1 ☐ Yes 2 ☑ No Specify: Wh									
ombiocod by	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business									
	(Specify only highest grade completed)	life DC	ind of work done during NOT use retired)	most of working	-1		,			
3	Elementary/Seconday (0-12) College (1-4 or 5		f Petty Off	icer		Navy				
3	17. Father's Name (First, Middle, Last)			Mother's Name (F	irst Middle Mai					
2	• • • •					den damane,				
П	George Drude			rtha Ko						
П	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and No	ımber or Rural Ro	oute Number, Ci	ty or Town, State, Z	Zip Code)			
П	Donna Demay / Daughter	848 M	lago Vista F	d. Arno	ld, MD 2	21012				
	20a. Method of Disposition	20b. Place of Dispos	sition (Name of atory or other place)	Date	e 20	c. Location - City o	or Town, State			
-	1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ey Cremator	3/15/	2011 1	woodhi na	Maryland			
	21. Signature of Funeral Service Licensee									
	Brundy Hockortin	MO1251 Be	ing Home Cr	emation	Service	P.O. Bo	x 784 le, MD 21029			
-	LEVELLY FIREMOTIC									
ı	23a. Part 1. Enter the lisease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not enter	r the mode of dying, suc	h as cardiac or re	spiratory arrest,		Approximate Interval Between			
П	Immediate Cause (Final disease or condition	tate	Cancer	A			Onset and Death			
П	resulting in death)	consequence of):	1 407 (6)							
П							years			
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a			1-27						
	if any, leading to immediate Due to (or as a Cause (Disease or linjury	,								
	that initiated events C.	C. Due to (or as a consequence of):								
ı	resulting in deathy East	oonooquonoo on.								
	d									
	IF FEMALE:					T				
1	23b. Was decedent pregnant 23c. If yes, outcome of	of pregnancy 2 Fetal death 3	Ectopic pregnancy			23d. Date of d	lelivery			
	1 Vec 2 No 4 Pregnant at		Other (specify)			Month	Day Year			
.	9 Unknown									
	Part II. Other significant conditions contributing to death but	ut not resulting in the ur	nderlying cause given in	Part I.	23e. Did tobac	cco use contribute	to the cause of death?			
					1 ☐ Yes	2 No 3 □	Probably 4 🗆 Unknown			
٠Į					24a. Was an autopsy	prior to	utopsy findings available completion of cause of			
ı					performe	d? death?	es 2 No			
1	25. Was case referred to medical		26. Place of	Death (Check on			00 2 2 7 10			
ı	examiner? 1 Ves 2 No Hospital:	nt 2 ER/Outpatient	Other			0 0 0 0	14. 1			
1	27. Manner of Death 28a. Date of injur		28c. Injury at		Describe how	ce 6 Other (Spe	эсіту)			
	1 Matural 5 ☐ Pending (Month, Day,		work?		. Describe now	injury occurred				
1	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
1	P P									
	29a. Certifier (Check (ny knowledge, death or	ocured at the time, date	and place, and d	ue to the cause	s) and manner as s	tated.			
-	only one) 3 Certifying Nurse Practioner: To the basis of ex									
Î	29b. Signature and title of certifier		29c. License numb	er	29d	. Date signed (Mon	th, Day, Year)			
	Januatra donner	MO	022	8 11	O	3 11 1	2011			
ŀ	20 Name and address of a second side and the	oath (Itam 22a) (Time D	int)) ;		21	-			
	30. Name and address of person who completed cause of de	aur (item 23a) (Type, Pr		steA	6/2 12	uch's M	0.101.			
	Jonalhan Joiman MD.	MULLANDARI	KVILLIN 27	JEEL	9 RUV	UN INE, IN	1 1 (1 (p)			
	21 Date filed (Month Day Veer)	'a Clanet								
	31. Date filed (Month, Day, Year) 32. Registra	's Signature	1							

State Registrar

Physician/ Medical **Examiner Funeral** Director or 28a-f shov the Maryland event, the Medical Examiner must be notified at Director Funeral with 1 items 23a ò ð 21215-0036 "natural", Completed than and Mental Hygiene. is marked other tha Be ൧ permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked injury or other traumatic Baltimore, Physician/ Medical Examiner Examiner and attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the all d be detached for þ Completed Be ၉

ARROL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 4:15 P.M. 2011 Carroll Charles DelGavio 4a. Facility Name (if not institution, give street and number) 4b. Citv. Town, or Location of Death 4c. County of Death SQUARE FRANKLIN ROSEDALE BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex. 1 A M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Months Country)
Maryland 217-24-9071 80 June Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗓 No Md. Balto. White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Bangert Street USA 21162 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 by Yes 2 \sum No If Yes, Give 1 0 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White ir tes, Give Year or Dates. 1948-1949 Specify: 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tile Contractor Self-Employed 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dominic DelGavio Alice Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne DelGavio Spouse 5400 Bangert Street White Marsh, Md. 21162 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Parkwood 3-17-2011 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Servi Servi 22. Name and Address of Facility Schimunek FuneralHome THE 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONI disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 4 Pregnant a 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULMONARY FIBROSIS 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No COLON CANCER 24a. Was an autopsy performe 24 hours after death.

Funeral Director: After this certificate has CANCER BLADDER 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural iniurv 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Lecrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 0000 MARCH 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237 SHAIKH M.D 31. Date filed (Month, Day, MAR 15 32. Registrar's signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03-09-20 Pay 600 A Margaret DiDio Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours 1 □ M 2 🗓 F 04-07-1915PA 217-20-6050 95 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 51 Chapeltowne Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give White Specify: Completed 3 X Widowed 4 Divorced Year or Dates is marked other than "naturaumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sera Bellaera Jack LaRocco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Samuel DiDio (son) 1407 Bonnett Place Unit E Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holy Redeemer Cem. 03-12-2011 |Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Sign ture of Funeral Service License eer Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final SANKE Pnysician/ disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 2 No q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 21HIE 1 Yes 2 No 3 Probably 4 Unknown certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 NO မ 1 Tyes ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Certificate: After work 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death

Director: A

in by the f Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in my analysis. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signaty D 58303 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

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2. Registrar's Sign

N. Chances

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March Willie Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 4702 Homesdale Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 06-15-Days Hours 1 X M 2 🗆 F Director 237-52-386 84 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21206 4702 Homesdale Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etcAfrican Demor Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give hours after Maryland 21215-0036 1 Yes 2 X No Specify: SpecifyAmerican 3 X Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 72 St. Joseph College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the ionee. Laundry service Hospital 7th Grade NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Classv Demory Charlie Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4702 Homesdale Avenue Baltimore, Phyliss D. Long-Daughter Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place King Mem. Pk. 1 ABurial 2 Cremation 3 Removal from State 03-12-11 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gilmor Street Baltimore, MD 21217 638 23a. Part 1. Enter the disease, or complice ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown a | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autonsv 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 🗌 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined within 24 hours after To the Funeral Direc City or Town, State) Medical 1 > Certifying Physicia To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examination in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying y-urse, ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Yelr) 29c. License number 29b. Signature and title of ce

3. Time of Death

9. Birthplace (State or Foreign Birthpia Country) NC

10d Inside City Limits

1 ¥ Yes 2 ☐ No

21206

Approximate Interval Between Onset and Death

Voar

Day

1 Yes 2 No

Month

2011

5:15 P м

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene- State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - 2<u>011</u> Physician/ 7:50 PMM 13 March Dunne Medical .Tohn Patrick 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death White Marsh 11210 Philadelphia Rd. Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months Davs Hours Min Tllinois 1/5/1932 Director 213-28-0424 79 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have acted. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13226 Eastern Avenue U. S. Was Decedon.
Armed Forces?

1 24 Yes 2 No
1 No
1 1949/55 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) awn Maintenance Contractor Lawn Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Patrick Dunne, Sr. Margaret Anne Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River, Maryland 21220 Alice T. Trent (Personal Rep.) 9 Compass Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City, MD Bayview Crematory 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Maryland 21221 Fail 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physiciani Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. E. nor on denying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) 4 Pregnant
9 Unknown Pregnant at time of death signed by the ar 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed nas been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate I After this certification funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 N Other (Specify) Residence Hospital: မြ 2 **X**No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury 1 X Natural 5 Pending death. 2 Accident Investigation within 24 hours a er deat To the Funeral Director completed filled i by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D69827 201

State Registrar

DHMH 17 Rev 7/2009

22 S. Greene St., Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINGH, SUKHWAINT NIKKI, MD;

15

31. Date filed (Month, Day, Year)

MAR

11-01859					
Dawn Duncan					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month Day March 5, 2011 Medical Examiner 2357 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Foreign Director Months 1 M 2 F Country) 56 -840 Yrs Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Opparment of Health and Mental Hygiene. Opparment of Health and Mental Hygiene. Importantly, or items 23a or 28a-f sho important. If item 25a or 28a-f sho aliury or other traumatic event, the Medical Examiner must be notified at once. 1timor Director 10e, Street and Number 10g. Citizen of What Country? 509 21224 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 Never Married 2 Yes If Yes, Give Year or Dates: 4 Divorced 1 Yes 2 No specify: White Specify: 5 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Schuh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - Cit√ or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley - ASKION FUNERAL HOME Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Intracerebral Hemorrhage Associated With Combined Approximate Interval **Physician** /Medical Death Immediate Cause (Final disease Narcotic (Methadone and free Morphine) Intoxication xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and trans Physician/Medical AMENDED 23a,27,28a-f,g914 5-13-11 sm attending physician or use as the burial -X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy 1 Live birth Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been uneral director, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 📗 DOA Other Nursing Home 5 Residence 6 Other: 1 Yes 28a. Date of Injury (Month, Day, Yeer) 27. Manner of Death 28b. Time of Injury 28d, Describe how injury occurred 28c. Injury at Work? 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5 Pending 1 Yes 2 X No fd 3-5-11 Unknown Unknown 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 509 Rapolla St. Baltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined 4 Homicide (Specify) Residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.EOCME March 9, 2011 30. Name and address of person who completed cause of death (flem 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

OCME 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per INF G916 6/14/2011 JH State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 03 6:45AM Adina 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore Examiner 4b. City, Town, or Location of Death Hospice OWSON Gilchrist 097542501 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Jumaica If Under 1 Year 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Months Days Min 1 M 2 X F (Month, Day, Year) Yrs. Director 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f, Zip Code ò 10g, Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral Cloville USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare 4dmin ssistant 241 avade Be 17. Father's Name First, Middle, Last) LUNK 18. Mother's Name (First, Middle, Maiden Surname) 0 auretta bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 2210 Clouille Avente Ba Michelle E. Dale aught-ev Itimone MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Woodlawn Cemetery Woodlawn, MD 2011 Variatin C. Greene Filheral services Signature of Funeral Service Licensee Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysicient An disease or condition resulting in death) Crea months Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) WOSFI U 은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 March 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANNE 6701 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10c Per FH 9913 3/15/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-Decedent's Name (First, Middle, Last) 2. Date of Death Month / - 2011 Physician/ Medical 4a. Facility Name (if not institution, give street and number, County of Death Examiner Nursing timore . Birthplace (State or Foreign Country) 8. Date of Birth Funeral Months Hours Min. (Month, Day, Year) 40-7234 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** Baltimore 1 Yes 2 No MI VIOLV 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2/22 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory on other ■ Burial 2 □ Cremation 3 □ Baltimore, 19-2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Van 23a. Part 1. Eyte the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final √h, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 🗌 No Unknown 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) funeral director. Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ျင 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural injury 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c License number) 2 1649 29b. Signature and title of certific March 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 WILKENS AVE BALTIMORE, MD 21229 SAMBANDAM BASKARAN 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201 2025 SARAH MAJZCH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hospital Center Randallstown 6. Sex 1 \(\text{M} \) 1 2 \(\text{X} \) F 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) AK (Month, Day, Months Davs Hours Year **Director** 466-38-7573 80 Oct. Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item. 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits MD Carrol1 Westminster 1 Ves 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1264 Emerald Ridge Road 21158 U.S.A. 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by If Yes Give 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+ Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Ethel Weeks Louis Rilev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reisterstown, Maryland 21136 Evans Daughter 12276 Bonmot Place Jackie 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 3/5/11 Hampstead, Maryland 4 Donation 5 Other (Specify) Carroll Cremation,Inc. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CARDIORESPIRATORI Medical Due to (or as a consequence of) Examiner FAILURE Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ALCOHOLIC CIRRHOS attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical PORFORATED SIGMOID DIVERTICUUTS To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Naturai (Month, Day, Year) 5 Pending injury work . o. .s after de... .eral Director; A'
rd filled in by thr 1 Yes 2 No Accident Investigation ☐ Acciden
☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🄀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practionar to the best of my knowledge, death uncurre only one ed at the time, date and place, and due to the cause(s) and manner as state 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) D3613 Z 3 2011 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Philip Franklin, M.D. 5401 Old Court Rd. RAndallstown, MD 21133

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

parker

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 1:30 PM Physician/ March 13, ^{Year}01 Marjorie Ellen Elliott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Baltimore Towson 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year 8. Date of Birth 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 M 2 F Month, Day Ye Aug 17, Year) 1924 Months Days Hours Min. Michigan 86 Director 302-16-2727 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21234 3213 Chesley Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Giv 1 ☐ Yes 2 ☐ No Specify: White 3 ₩idowed 4 Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hospitality Restauranteur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arfa Schumaucher Edward Guden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Townsend /Daughter 3213 Chesley Avenue Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ^{Date} Mar 15 1 Burial 2 Cremation 3 Removal from State permit, Page Department of Important: If any injury or Beltsville, Maryland Chesapeake Crematory 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives MO1443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Illimongro oar5 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No After this certificate 2 🗌 No 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) injaliens Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 **Ž**No 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at wo<u>r</u>k? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident
Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my existed. Medical 29a. Certifier completed t Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

THAN

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 1 1 Day 20^{'1}1 Elsie M. Entwisle 4:40 PM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min. Months 1 □ M 2 □ **X**F 84 7-25-1926 216-20-2888 MD **Director** Usual Besidence of Decedent show ms 23a or 28a-f shor must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8806 Wolverton Road 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 → Widowed 4 □ Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Johns Hopkins Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Public Health Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Michael Joseph Miller Mildred Naomi Hergenhahn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 117 East 25th St., Baltimore, Jane Shipley - Daughter MD 21218 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 3-13-11 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee THURK PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) signed by the aid be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗡 No 3 ☐ Probably 4 ☐ Unknown POLYCYTHEMIA VERA Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC KIDNEY DISEASE 24a. Was an page 2 s autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) to ortage 1 ☐ Yes 2 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Medical Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Lamo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Le NIS Street 31. Date filed (Month, Day, Year) MAR 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

11-01971

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene Tanise Ervin 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1829 hrs March 12, 2011 **Medical Examiner** Tanise Nakisha Ervin tc. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Country) 216-35-1787 Days Months Hours 03-8-1992 Director 19 2 XF 1 M Usual Residence of Decedent 10d. Inside City Limits 10a. State MD 10c. City, Town or Location M Baltimore 1 X Yes 2 No or 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural?" or itemating to other traumed. Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 MD 932 Gorsuch Avenue Apt. 101 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Black Yes 1 Yes 2 No specify: Specify. 3 Widowed 4 Divorced If Yes, Give Year 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired)
FOOD Service Completed College (1-4 or 5+) Restaurant Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juanita Brown Be Tobby Ervin 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 932 Gorsuch Ave. Baltimore, MD 21218 932 Gorsuch Ave. Baltimore, Juanita Brown Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, st.Stanislaus Cem 3-19-20 1 X Burial 2 Cremation 3 Removal from State Baltimore MD Donation 5 Other Specify: 22. Name and Address of Facility Phillip Weatherford_{FS} PA 22 Name and Address of Facility Phillip A. Weatherf 2431E.Oliver St. Balto MD 21213 21. Signature of Funeral Service License Approximate Interval Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and one cause on each line (Medical Death a Gunshot Wound of Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical UNPENDED AMENDED attending physician for use as the bunal The law requires that the death certificate be Box 68760 23d. Date of delivery IE EEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Year Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for Unknown n signed by the a 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed has been si 2 should b 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? performed? page ✓ Yes 2 No 1 Yes this certificate 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 Inpatient examiner? Other Nursing Home 5 Residence 6 Other: 2 PER/Outpatient 3 DOA ဥ 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Certification: Subject shot Mar 12, 2011 1800 hrs 1 Natural 1 Yes 2 ✓ No d in by the f 5 Pending death 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 6 Could not be Suicide or Town, State) 1100 Gorsuch Avenue, Baltimore, Md. determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 13, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD

OCME 2006

State

31. Date filed (Month, Day, Year)

strar's Signature

Ensur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 07^{Pay} 03mth Physician/ 20°11 Narre 18:40p M Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner 3734 Elmora Ave. <u>Baltimore</u> Social Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Unde Funeral 1 🕱 M 2 🗆 F Months Days 0270671929 S.Carolina 214-26-9709 82 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🏋Yes 2 🗆 No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3734 Elmora Ave. S. 21213 U. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒No Black, White, etc 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Black Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 3rd Grade College (1-4 or 5+) Rubber Co Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 <u>Loui</u>se Unk Joseph Ellison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellison(wife) 3734 Elmora Ave., Baltimore, MD <u>21213</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State King Mem. Park 03/15/11 Baltimore, MD 4 Donation 5 Other (Specify) 21. Sign sure o Funeral , rvice Licensee 引擎網絡網。 FBFown Jr. 2140 N. Fulton Ave., FuneralHome Baltimore, MD 21217 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between nset and Immediate Cause (Final disease or condition Physician/ neer hou Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Other (specify) Pregnant at time of death signed by the at Id be detached for Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ☐ No 3 ☐ Probably 4 🗖 Unknown Completed Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed?

1 Yes 2 No 2 X No After this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 X No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ Manner of Death

Natural

Accident 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after deal Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier D30661 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, ND 21239 5601 Loch Raven Blvd Sireesh K. Tripuraneni 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

MAR 15

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per PHY G913 3/18/2011 JH State of Maryland / Department of Health and Mental Hygiene 08054 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Lillie Franklin Month Physician/ 9:40am M Franklin marc Allicen 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore N Baynew Medical Center phins Hopkins 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 7. Age (In yrs. last birthday. Social Security Number 6. Sex Funeral Novin By, Year) 1 🗆 M 2 🖫 F Days Hours Min. Country) · Texas Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 Yes 2 No MT altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21048 Ver Meadows Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Completed by Maryland 21215-0036 1 Yes 2 No Black If Yes, Give Year or Dates Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) ၉ emier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21045 19a. Informant's Name/Relationship (Type, Print) Meadows olumbia 7 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State Dallas and Henough 4 ☐ Donation 5 ☐ Other (Specify) Laurel Signature of Funeral Service Licenses 22. Name and Address of Facility Howell - Leveral MD 20194 tood 10720 Just Jesse 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chuoni ebshutive pulmonau disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner dequee burn Sequentially list conditions, MEDICAL EXAMINER Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 20 415 Severe demonto To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit ETTFICATION APPROVED Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 2 X No Yes 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 2 No 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 🗷 No 5 Pending ☐ Natural foot Scald burn 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) to Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined River meadous Pr. Columbia MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier RES-DOD mo March 14 ADA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 Erstern Bultimore MD 40 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 5 2011 arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9931 Liberty Rd. Randallstown Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖳 M 2 🗆 F Months Days Hours Min (Month, Day, Year) Director 57 Yrs 215-64-5260 Maryland 1953 Nov 24 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States Liberty Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. d Force 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 🗆 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify 3 Widowed 4 Divorced 1970-7 Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) 3 Computers Programmer Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 Ben Fine Edith Feld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Smith /Wife 9931 Liberty Rd. Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beltsville, Maryland 2011 <u>Chesapeake</u> Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Director: After this certificated in by the funeral director, pag 2 🗌 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury_at 28d. Describe how injury occurred 1 Natural 5 Pending 1 \square Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a To the Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License numbe Date signed (Month. Dav. Year)

State Registrar Date filed (Month, Day

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who completed cause of death (Item 23a) (Type

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Şignature

COASE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2011 Robert Faulkner 6:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Rockville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Year)
Dec • 24, . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 🗆 Months Davs Hours United Kingdom Director 90 1920 212-54-0578 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3532 Chiswick Court 20906 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White etc 1 Never Married 2 X Married þ 1 Yes 2)
If Yes, Give
Year or Dates. 2 X No Baltimore, Maryland 21215-0036 1 Yes 2x No Specify: "natural", White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea gines. College (1-4 or 5+) Elementary/Seconday (0-12) Printer Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Robert Fau1kner Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorre Ann Faulkner / Wife 3532 Chiswick Court, Silver Spring, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 03/11/2011 Beltsville, MD 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner neumoru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit hydra that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as the IE EEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv performed death? 1 ☐ Yes 2 ☐ No the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 9c. License number D0068026 MD 2011 03

Registrar

State

Drive

BAND,

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PADMAJA

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prince

31. Date filed (Month, Day, Year)

Phillip

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G913 3/15/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 aci. 306 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Amore Baltomore 80 If Under 1 Year If Under 24 Hrs. '.Age (In yrş. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F JULY 17 Months Days Min. **Director** .1969 41 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 XYes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? be or items 23a curiner must be Funeral 208 N. FULTON AVENUE 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner 1 Never Married 2 Married Black, White, etc. Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: BLACK the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2 TEST COORDINATOR PROMETRIC Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other there. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ DENNIS ROBINSON, SR. ROSLYN FORDBEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
208 N. FULTON AVE. BALTIMORE, MD 21223 ROSLYN FORDBEY/MOTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING MEMORIAL PK 03/18/2011 MORTUNO A SUNS F.H., INC. Signature of Funeral Service Licensee 22. Name and Ad ress of Facility 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner attending physician and for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ≥ L g ☐ Unknown been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t page 2 autopsy performe . 24 hours after deatn.

• Funeral Director: After this certificate I was filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗌 No |요 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 🗌 Yes Investigation 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) a 31. Date filed (Month, Day, Year) 32. Registrar's S State Registrar

DHMH 17 Rev 7/2009

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	Physici	an	1. Decedent's Name (First, Middle, Last)	NGTON IC			2. Date of Death	9 pay 201 Ye	3. Time of Death 7:26a M
/Medical /HOM #5 B / HIVOVIII 37						r Location of Death		4c. County of D)eath
			Bay Ridge Healthcare (Annapo		0.00.4.75.4	Anne A	
	Funeral Director		244-28-6008 1 1 AM 2□F	Age (In yrs. last birthday Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04/16	/1926	Birthplace (State or Foreign Country) NC
	aryland show d at	Į.	Usual Residence of Decedent 10a. State 10b. County Anne Arundel	10c. City, Town or L Annapo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the Market 28a-f	recto	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	
	ath with	ral D	900 Van Buren Street		2140			USA	1 1 1 1
036	y within 72 hours after death with the Maryland piene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 11 Sys, Give Year or Date	□No	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc. lack
215-0036	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occup ve kind of work done . DO NOT use retired	eation during most of workin	9	16b. Kind of Busine	ess/Industry
717	filed within 7 Hygiene. other than "r ent, the Med	dwo	Elementary/Secondary (0-12) College (1-40	ir 5+)	Homema!			Hom	emaker
yland	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) Thomas Buddy Farringt	on Sr		18. Mother's Name	(First, Middle, M		
Ja	and 2 should ealth and Men n 27 is marke ier traumatic	_	19a. Informant's Name/Relationship (Type. Print) Martina Bais Auth Age		iling Address (Street A Marcs				te, Zip Code) 1 4 0 3
gaitimore,	- 7 5 5		20a. Method of Disposition 1 □ Burial 2 1 Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	20b. Place of Disp cemetery, cr Atlant:	position (Name of rematory or other place ic Crem	o3/1	5/2011	20c. Location - City Glen	or Town, State Burnie MD
Balt	permit. Pages: Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licensee						& Fun Serv Hanover MD
, ,	death certificate be executed Medical Examiner and physician and dior use as the burial-transit	ical Examiner	if any, leading to immediate	as a consequence of): as a consequence of): as a consequence of):	Cardiovaso	cular Dise	ease		Interval Between Onset and Death
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J.	requires that the een signed by th hould be detache	by	Part II. Other significant conditions contributing to death HTN (Hyputunm	but not resulting in the	underlying cause giv	en in Part I.		es 2 No 3[te to the cause of death?
II Records,	The law requate has been page 2 should	Completed	Peripheral vascular	disease			24a. Was ar autops perforn 1 Yes 2	y I prio	re autopsy findings available r to completion of cause of th? Yes 2 \(\square\) No
VII	Physician: this certific al director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp.	atient 2 ☐ ER/Outpati	iont 3D DOA Oth	26. Place of Death			(0)
101	ding Physician: n. After this certific funeral director,	n: To	27. Manner of Death 28a. Date of I		of 28c. Injui			ence 6 Other (ow injury occurred	Specify)
UNISION	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be	injury - At home, farm, s	M 1 🗆	Yes 2 □ No	8f. Location (Sti City or Town	reet and Number on, State)	or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the basis and manner and manner	s of examination and/or					
)	To th withir To th comp	Me	29b. Signature and title of certific		29c. Licens	63681	29	3 ic 20	
	\ \		30. Name and address of person who completed cause of Ajit Kurup 1835 Uni			attsville	e MD 20	0783	
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 1 5 2011 Security	istrar's Signature	lad				
			MAK I U ZUII JOHUNG						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 201 Allen Stewart Fennington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Good Samaritan Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. . Social Security Number Birthplace (State or Foreign Country)
 Maxwell and 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min 04-22-194 Year) 1 🛛 M 2 🗆 F 220-36-5510 Maryland 69 Director Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 3629 Raymonn Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 10 · 1 Never Married 2 X Married Completed by 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Printing Industry Printer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Ellsworth Fennington Olive Elizabeth Herwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3629 Raymonn Avenue Baltimore, Maryland 21213 Mrs. Joan Fennington - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, cremetory or other place)
Hilltop Service Corporation 03-18-2011 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility Signat e Funeral Serfice Licensee 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or). attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown 2 No signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director; I Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔲 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis or examination allows investigation, in this opinion, data and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie merch or D March 12, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samaritan Hospital: MD 21239 SHASHIDHARAN 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. Nor-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12^{Day} Physician/ Arnold Thor Grahn 20**11** 8:05 A M March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Center Baltimore Towson 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) an. 10,1921 Country) Maryland Days 1 □**X**M 2 □ F Months Hours 90 220-01-1099 Jan. **Director** Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director Parkville Baltimore Maryland 1 Yes 2 No 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 8810 Walther Blvd., Apartment 3114 United States 21234 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No 1942
If Yes, Give 1044 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 Yes 2 No Specify. Specify: White - 1944 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) during most of working Department of College (1-4 or 5+) Elementary/Seconday (0-12) Defense Contract Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Axe1 Edward Grahn Maria Friman permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic o 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8810 Walther Blvd., Apt. 3114, Parkville, MD 21234 Catherine V. Grahn / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/14/2011 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Allyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Kin 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Pnysician non-hodgins water disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown icate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No Yes 2 the Hospital or Attending Physician: Inin 24 hours after death.

the Funeral Director: After this certifica pleted filled in by the funeral director, the funeral director is the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence ≥X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) injury 5 Pending Investigation
6 Could not be M ☐ Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Blud

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month! Day, "Tear)

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	_		1 - State Of State Of Registrar	iviai yiai		tificate of		,	gierie Reg. No.	
П	Physicia		1. Decedent's Name (First, Middle, Last) Luella Eunice	Glas	SOOM			2. Date of Dea Month	nth Day Yea	3. Time of Death
A		Medical Examiner Luella Eunice Glasgow 4a. Facility Name (if not institution, give street and number)					or Location of De	March eath	11, 201 4c. County of De	- 1 - 1100
	/		7400 Holly Ave.			Takoma Park			ĺ	gomery
	Funeral Director		5. Social Security Number (Unk •) 6. Sex 1 □ M 2 🏋 F	. Age (In yrs. I 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours M	Hrs. 8. Date of Birt Min. (Month, Day Sept. 2	1, Year) 1930 P	Sirthplace (State or Foreign Country) ennsylvania
	d tow	Ļ	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Loc	action				
	larylar 3a-fsh iffied	Funeral Director	MD Montgomery	100.01	ty, fowil of Loc	Takoma	Park			10d. Inside City Limits
	the Na or 28	Ξ	10e. Street and Number			10f. Zip Code			10g. Citizen of What	
	th with ms 23 must	iner	7400 Holly Ave.			209			United	
9	er dea or itel miner	by Fu	11. Marital Status 12. Was Deceded Armed Force 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2	es?		Vas Decedent of Yes, specify Cub	Hispanic Origin? van, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
21215-0036	ours aft tural", al Exal	ted t	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Date		1	☐ Yes 2XXN	o Specify:		Specify:	White
215-	72 ho an "na Medic	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occu iind of work done O NOT use retired	during most of v	working	16b. Kind of Busines	s Industry
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aryl	nould brind Me s mark		19a. Informant's Name/Relationship (Type, Print)	wonger		a Address (Street			lilah City or Town, State, 2	Carrier
Σ,	nd 2 s lealth s m 27 i		Kristen Gorman / Daughte		7400	Holly A		koma Park		
nore	age 1 a ent of H nt: If ite y or otl		20a. Method of Disposition 1 ☐ Burial ZXXCremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	tate C	emetery, crem	sition (Name of latory or other pla ke Crema		Date 1.4./2011	20c. Location - City of Beltsvi	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			W00382					Services	rie, mb
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	Physician/		23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Immediate Cause (Final	line.	-	i			est,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Due to (or	as a consequ	uence of):	en Cail	4 / Cuno	М с-		
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3760	ficate k g physi	l edic	d							
Box 6876(eath certificate bo attending physic I for use as the b	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 □ Live Bir	me of pregnar th 2 Feta	ıl death 3 🗌	Ectopic pregnan	су		23d. Date of d	*
. Bo	that the deat ned by the at detached fo	Physician/Medic	in the past 12 months? 1 Yes 2 No 4 Pregnat 9 Unknown 9 Unknown	nt at time of d	death 5	Other (specify) _			Month	Day Year
P.O.	res that the signed by the deta	by Pi	Part II. Other significant conditions contributing to deat	th but not resi	ulting in the ur	iderlying cause g	iven in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
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Seco	2 00 01	Completed						24a. Was a autops	sy prior to med? death?	
talF	sician: The la certificate ha irector, page 2		25. Was case referred to medical examiner?				lace of Death (C		2 No 1 ⊔ Y	es 2 No
f Vi	Physion this contained the	2	1 ☐ Yes 2 ⋈ No Hospital: 1 ☐ Ing 27. Manner of Death 28a. Date of i		ER/Outpatient	3 DOA Oth	4 L Nursing		ence 6 Other (Spe	cify)
o uo	ath. r: After ne fune	icate	1 X Natural 5 ☐ Pending (Month, 2 ☐ Accident ☐ Investigation	Day, Year)	injury	wor		28d. Describe no	w injury occurred	
Division of Vital Records,	or Atte	Certificate:		Injury - At hor etc. (Specify)		et, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) only one 3 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								tated.		
								cause(s) and manner stated. s stated.		
	2 ≥ 2 ⊗		290. Signature and the of dentile			1	6 H 37		9d. Date signed (Mon	
	101	-	30. Name and address of person who completed cause of	of death (Item	23a) (Type, Pr				0 17-6	20815
	ı		Steven A. Burka M.D. 31. Date filed (Month, Day, Year) 32. Regi	5530 strar's Signatu	Wiscor	inti isin Aug	7914	Cherry Cl	rase ME	20812
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 2011 Ρ 7:00 ETHEL JUANITA GENETOS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL GENESIS ELDERCARE-HAMMONDS LANE BROOKLYN PARK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F Director 219-18-8191 April 29, 1923 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4121 Grace Court 21226 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: ð 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food Service permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other I any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Hart Nellie Rebecca America ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Crews 4121 Grace Court; Baltimore, MD 21226 Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 3/18/2011 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service L shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Dneumonie weck /Medical Due to (as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed /us Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 2 No Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 22100 2 500 1 TYes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred D Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year)

901 13421

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

w

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4.00 DM GERRAGE DOUGLAS LEON 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Regional PRINCE Hospital Loure GEORGES Year If Under 24 Hrs.
Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Aug. 22, 1945 Months Days Director 216-48-1597 65 VA Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard 1 Yes 2XXNo Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8864 Willowwood Way 20794 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 XMarried þ 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXXNo Specify: Specify: White Completed 3 Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Elevator / Construction 4 years Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (unknown) Rhea George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Ann George spouse 8864 Willowwood Way Jessup, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X remation 3 Removal from State Arundel Crematory 4 Donation 5 Other (Specify) 3/15/2011 Odenton, Maryland 21. Signature of Funeral Service Licensee 22Dona de fineral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate shock, or heart failure. List o Interval Between Onset and Death Immediate Cause (Final Physician/ neumo nia disease or condition Medical resulting in death) Examiner Pancreate Carcer Metaltalic Sequentially list conditions, it as year cause. Enter Underlying Cause (Disease or iinjury that initiated events ner and I-transit Exami or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last signed by the attending physician and be detached for use as the burial-Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of has autopsy performed' death? Director: After this certificate 1 ☐ Yes 2 ₺ No 1 Schenic Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 2 **N**o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗌 Pending injury work? 1. ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Larumus 3, 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7360 Van Dusen Road Adedei houvel Regional a- wow Laurel MD 31. Date filed (Month) Pay, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 201 4:05 PM Martin E. Greenway Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Laurel Regional Hospital Prince George's Laure 5. Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD If Under 1 Year 7. Age (In yrs, last birthday) **Funeral** 1 **xx**M 2 □ F Days Hours Min. oct. 26,1957 Months 53 Yrs. MD Director 214-72-0676 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3372 Crumpton South USA 20724 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2XX Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Superintendent Commercial Roofing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ۵ Kenneth Eugene Greenway Silvia J. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia D. Greenway/ Wife 3377 Horsehead South, Laurel, MD 20724 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 11, cemetery, crematory or other place) 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State Union Cemetery 2011 Burtonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01053 313 Talbott Ave., Laurel, MD 20707 ken Skile 23a. Dert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ventricular Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Myocardial onehour Sequentially list conditions, iner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Exam that the death certificate be executed orondry ears that initiated events Due to (or as a consequence of) resulting in death) Last Post Physician/Medical Stent Cardiac Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Mellitus or Attending Physician: The law requires after death. Didbetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Multiple Sclerosis Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Abuse on performed death? Substance Methadone this certificate 2 No 2 X N Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 X No Other: Certificate: To 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital o within 24 hours aff Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier U1. X 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 7300 Van Dusen Road Regional Hospital Emergency Wang Koon, Laurel aurel 31. Date filed (Month Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

tay

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RUDOLPH GREENWAY March 13 10:15 PM^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8 Ensign Court Essex Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1**X** M 2 □ F Months Hours 07/18/1947 Virginia **Director** 047-36-3615 63 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 X No Essex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Ensign Court 21221 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 27 is marked other than "natural", or iter traumatic event, the M-dical Examiner Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1965 þ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: 3 Divorced 4 Divorced 1969 Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Electronic Technician Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornelius Greenway Rosa Lee Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Deremius Greenway (Wife) Page 1 and 2 8 Ensign Court, Baltimore, Maryland 21221 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place New Bern Memorial Cem 03/15/2011 New Bern, N. Carolina 4 Donation 5 Other (Specify) Signature of Fundania 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final d. ase or condition resulting in death) Onset and Death enysician/ HEPATOCELLULAR CARCINOMA METASTATIC Medical Due to (or as a consequence of) Examiner Ocquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the Limit of my knowledge: Seath occurred at the time, date and place and due to the cause(s) and manner at stated. (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2011 M.D MARCH 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 1838 GREENE TREE ROAD #300 PIKESVILLE MP 21208 LEONARD RICHARDSON

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** 20 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give Riverview Care 4b. City, Town, or Location of Death street and number. **Examiner** Center Baltimore Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 3 (Menta Day, Year) 4 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Hours Min. Months Days 1 M 2 DE 219-52-2695 76 Greece Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show r than "natural", or items 23a or 28a-f shov the Wedical Examiner must be notified at 1X Yes 2 ☐ No Director Baltimore City MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 730 Rappolla Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: ģ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 ! (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important; If item 27 Is marked other any injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Toula Katsidonis Moshos Stratis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 730 Rappolla Street, Baltimore, MD 21224 Harriet Georgas - Daughter Baltimore, 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 3-16-2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licens PAL 2134 Willow Spring Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dung, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi ICYTOPENIA Due to (or as a consequence of) physician at the burial P.O. Box 68760, Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Yes 2 No 3 Probably 4 Inhown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an as l autopsy page certificate 1 ☐Yes 2 140 1 □Yes of Vital 2 **1** No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 the Funeral Director; After this upletely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide Hospital within 24 hours a 🕑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type Print) OTH AVE. #203, BALTOWOR

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 08068 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March ĭŸ, 20ĬĨ Goldberg 7:20 A M Murie1 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Chevy Chase Montgomery Brighton Gardens Chevy Chase 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea December 19 1 □ M 2 🖾 F New York 092-16-9543 . 1920 Director 90 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location the Maryland Director ems 23a or 28a-f sh r must be notified a Florida Palm Beach Boca Raton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 33428 United States 10851 Boca Woods Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, "natural", or itel Black. White, etc. , or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 27 is marked other than "natural traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Schwartz Sylvia Friedlander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Cheson / Son 11028 Waycroft Way N. Bethesda, Maryland 20852 other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ot
once. March^{Pate} 13. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Cremătorium, Inc 21. Signature of Funeral Service Licens Robert A. Pumphrey Funeral Home Bethesda-ChevyChase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Day shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or) as the burial-transit years Hypertension and and Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical years Hospital or Attending Physician: The law requires that the death certificate be Hyperlipidemia Box 68760 attending IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Month Day Year detached 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tor. After this certificate has been signed if the funeral director, page 2 should be det þ Records, 1 \maltese Yes 2 \square No 3 \square Probably 4 \square Unknown Stroke Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 X No death? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 4 Nursing Home 5 Residence 6 Other Specific Living ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 X Natural 24 hours after death. Funeral Director: A Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D34590 3-11-2011 no

Registrar

DHMH 17 Rev 7/2009

State

Roy Fried, M.D. 7758 Wisconsin Avenue, Bethesda, Maryland 20814 Room 211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

MAR 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month H 3:45 AM EEN 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death SECOURS RE MD MO 7. Age (In yrs. I 9. Birthplace (State or Foreign Country) South Carolina 5. Social Security Number 218-46-8007 If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months Hours Min. Month, Day Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipury or other 27 at marked other than "natural", and items to notified at any hipury or other 27 at many filed at a 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2404 Winchester Street 21213 MD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) Food Processor Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Willie Mae Hodges 2 Cornell Lowery 19a. Informant's Name/Relationship (Type, Print)
La Vonne Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 533 N. Milton Avenue Balto Md 21213 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, MD 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 3-18-2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility $Phillip\ A$ WeatherfordFS PA MUC 2431 E Oliver St. Balto I

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Md 21213 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, if any, leading to in insulate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed burial-transit Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No ed by the a 1 Yes 2 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 24 hours after death.

Lemeral Director: After this certificate has been sign teted filled in by the funeral director, page 2 should be teted filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Chknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? ormed? 2 No 1 Yes 2 No Yes Be **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 1 No 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann eath Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 00030355 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) BOX SECOURS 31. Date filed (Month, Day, State Registrar

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П	Physicia		1. Decedent's Name (First, Middle, Last					2. Date of Death	Day Year	3. Time of Death	
,,,,,	Medical Examiner 4a. Facility Name (if not institution, give street and number)						Location of Death		4c. County of Deat		
-	·		Seasons Hospice			Randalls			Baltimore		
	Funeral Director		5. Social Security Number 6. Se 217–92–7351	X M 2 □ F 7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 11–5–1956	9. Birt Con	hplace (State or Foreign untry) MD	
	how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Loc	eation				10d. Inside City Limits	
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	a or 2 be no	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?	
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9	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	by Fu	11. Marital Status 1 ☒ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces2, 1 Yes 2 A No		Vas Decedent of His f Yes, specify Cubar		Rican, etc.)	14. Race - Ame Black, White		
03	ırs aft ural", il Exar	ted t	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🕅 No	Specify:			Specify: Caucasian	
15-(72 hou 1 "nati ledica	Completed	15. Decedent's Ed (Specify only highest gra		(Give F	ent's Usual Occupa	ition n/a uring most of work	ing 16	6b. Kind of Business	Industry n/a	
21215-0036	vithin glene.		Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	O NOT use retired)					
73	교수들 =	To Be	17. Father's Name (First, Middle, Last) Carlen N. Hively	•			18. Mother's Nam	e (First, Middle, Ma. blnar	iden Surname)		
ary	should be file and Mental F 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Ty	pe, Print)	9b. Mailin	g Address (Street a	nd Number or Rura	al Route Number, C	ity or Town, State, Zip	Code)	
Σ,	and 2 s Health s tem 27 i	Ì	Cindy Ringler/Sister				Rotonda,	West Florid			
Jore	ge 1a nt of H :: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State ceme	tery, cren	sition (Name of natory or other place	" 3 -1 5-		20c. Location - City or Town, State Baltimore, MD		
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If Item 27 is any injury or other trai	-	4 ☐ Donation 5 ☐ Other (Specify 21. Signo ure of Funers Service License	A		. Name and Addres			Hume F.A. of		
ñ	permit Depar Impor any in		- Markey 1	1. Welle			- 23	llstown, MC			
	hysician/		23a. Part II. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the death. Do e cause on each line.	not ente	r the mode of dying	, such as cardiac (or respiratory arrest	,	Approximate Interval Between Onset and Death	
_	Medical Examiner	ı	resulting in death)	Due to (or as a consequence	e of):						
	- ±	iner	Sequentially list conditions, in any, Isaama to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequence	A			-			
6	be executed sician and burial-transi	cal Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence	e of):	-					
				d.	/-						
9289	tificate ng ph) as the	Med	IF FEMALE:								
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. When the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the I	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	 3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 		Ectopic pregnancy Other (specify)	/		23d. Date of del Month	ivery Day Year	
P.O.	hat the ed by detacl		Part II. Other significant conditions co	ntributing to death but not resulting	g in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
ls, I	uires t in sign uld be	ed by						1 ☐ Yes	2 🗆 No 3 🗆 P	robably 4 DunRnown	
cord	aw req as bee 2 sho	Completed						24a. Was an autopsy		topsy findings available completion of cause of	
Re	The la	Con						performe 1 Yes 2		2 🗆 No	
ita	ician; certifi ector,	Be	25. Was case referred to medical examiner?	lospital:		26. Pla	ce of Death (Check		10001	ant.	
λ	Phys r this eral dir	6	1 Yes 2 No	1 Inpatient 2 ER/0	Outpatien Time of	t 3 DOA Other	4 Nursing Ho	ome 5 Residence 28d. Describe how	ce 6 Other Spec	ity) hospice	
ouo	ath. r: Afte re fune	icat	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year)	injury	work's		254, 2555, 25 115 115 11	,,		
Division of Vital Records,	al or Atters all or after de Il Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								cause(s) and manner stated.			
	To th Within To th COME	-	29b. Signature and title of eertifier	3		29c. License			d. Date signed (Month		
			Lyber X	Deno			3337	N	larch 12.	7011	
_	V		30. Name and address of person whole	2835 SmH	1 Am	e Ste 203	Bulh	more, And	20209		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	ban	les .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #1 Per PHY b Per FH G913 3/15/2011 IH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Christian Hernandez-Sarmadi Month Year Alexander **Physician** 1842 M Christian March 5 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 08 | 05 | | 06 | 30 | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 220-87-8400 Director MD Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show her must be notified at 1 ¥Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f Zin-Code 10g. Citizen of What Country? Funeral 101 North Patterson Park Ave 21231 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify White 2 Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucio Hernandez Amber Huffman ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
410 N. Lehigh ST. 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any injury or other traus 410 Leighigh Street.

Date Amber Sarmadi-Mother Baltimore, Md 21224

20c. Location - City or Town, State Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 3/15/11 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 of Ameral Service Licensee maia Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a c' nsequence of): /Medical Examiner Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 🗆 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: $_4 \square$ Nursing Home 1 ☐ Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Natural 28a. Date of Injury 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred (Month, Day Director: After 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time date and place, and due to the 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 5,2011 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) larke 600 North Wolfe St, Baltimore, MD, 21287 Jessica -Pounder

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

3. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 Yahya Mahdee Hassan MV 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 3 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 00 Funeral Hours Min. Months 219-10-0480 1 ★ M 2 □ F Director 90 Usual Residence of Decedent 2011 10b. County 10c. City, Town or Location Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 4012 Chatham Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14 Bace - American Indian 03 Black White etc. Completed by 1 Never Married 2 Married Yes Give and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 □ Divorced Year or Dates San 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) American Airlines Sky Cap 6th grade Be (17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) ည Carrie Sterrett Thomas Sterrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214435 <code>Marriottsville</code>, <code>Road</code>, <code>Owings Mills</code>, Lanza if Health airem 27 i Michael Hassan-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specifit) permit. Page 1 Department of I Important: If it any injury or or cemetery, crematory or other place) Denation 5 ☐ Other (Specify) Baltimore National 3/15/201 Baltimore, Md Scnatus of Funeral Service Lice, see March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease Condition Ph_sician/ lications Medical resulting in death) Due to (o) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death the a 1 ☐ Yes 2 ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 | No Other: မြ Within 24 hours after death.

To the Funeral Director: After this c 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Mpnth, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending work? 1 ☐ Yes 2 X No 2 Accident 109/201 Investigation unkneww 3 Suicide
4 Homicide 6 Could not be 28e. Phice of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number) City or Town, State) 4012 Chatham Rd Woodlawn, Many Land 21093 determined Home Marylan Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHIL LLO 31. Date filed (Month, Day, Year)

3. Time of Death

9. Birthplace (State or Foreign

Black

10d. Inside City Limits

Interval Between Onset and Death

Day

Year

1 X Yes 2 No

12:27aM

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fh 9913 3-31-11 vt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Robert Joseph Hewins 12:00 PM /Medical MARCH 2011 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ST AGNES HOSPITAL BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 18 M 2□ F Months Days Hours Director 388-24-5041 82 June 23, 1928 Wisconsin Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evering must be event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 217 No MD Howard Elkridge Street and Number 10f. Zip Code 10g. Citizen of What Country? 6805 Iron Ore Unit 428 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∏ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Supervisor USPS 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Perley Albert Hewins ဂ္ Mary Kramer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Ross Hewins 1405 Forest Glen Court; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA Cem. 3/16/2011 Crownsville, MD 21. Sign wre Funeral Service 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year □Yes 2 □ No 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ADIOMYOPATHY Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown CHRONIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy CORONARY HEART 1 □ Yes Division of Vital 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 2 Accident investigation 1 ☐ Yes 2 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL DOCTOR D0069370 MARCH 11 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KWAME NTIM: 900 CATONS AVE. BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Hardy	State of Maryland / Department of Hea		e 2011 0807
Physician Medical Examine	Decedent's Name (First, Middle,Last)	2. Date Monti	of Death Day Year 1040 bro
nedical Examine	KODELL Haldy	Marc , Town, or Location of Death	2011 1940 hrs
	Union Memorial Hospital Balt	timore	NA
Funeral Director	219-38-2133 1 Mm 2 F 66 Yrs. Mor		e of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
any	Usual Residence of Decedent 10a. State		10d. Inside City Limits
8 .n	MD NA Baltimore		1 X Yes 2 No
with the Maryland ms 23a ur 28a-f sho be notified at once paral Director		tip Code 21218	10g. Citizen of What Country? USA
er death	1 3 Widowed 4 Divorced III Yes, Give Year 1 1 Vec	dent of Hispanic Origin? (Specify Yes cify Cuban, Mexican, Puerto Rican, et 2 X No specify:	White, etc. African
ours aft	15 Decodoratio Education (Capatity and highest grade completed) 140a Decodoratio Herrita Herri	al Occupation (Give kind of work done	Specify: American 16b. Kind of Business/Industry
b, MD 21215-0036 and 2 should be filed within 72 hour feath and Mental Hygiene. frem 27 is marked other than "natt traumatic event, the Medical Exat Traumatic event, the Medical Exat To Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 th Grade 1yr. College (1-4 or 5+) Labore		Ft. Knox Kentucky
Baltimore, MD 21215-00; pernit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumatic event, the Med To Be Comi		18.Mother's Name (First, M Doris Ma	
212 nould by id Ment is mark	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	ss (Street and Number or Rural Rou	ute Number, City or Town, State, Zip Code)
nd 2 sho alth and 2 cm 27 is	Irene Thomas-Sister 1182 E 20a. Method of Disposition 20b. Place of Disposition (N		kway Baltimore, MD
Baltimore, Dermit. Pages 1 ar Department of Hee Important: If ite	1 X Burial 2 Cremation 3 Removal from State crematory or other place	e)	-11 Randallstown, MD
altin mit. Pa partmen portan ury or			Funeral Home P.A. eet Baltimore, MD 2121
	2,00000		
Physician xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atheroscle Due to (or as a consequence of):		Between Onset and
944	Sequentially list conditions, b.		
	if any, leading to immediate Cause. Enter Underlying Cause C.		(4
W	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.		
60, he be execut ysician and burial - tra	▼ UNPENDED □ AMENDED 23a,27 per me g9	13 3-28-11 vt	55555 E1
(ecords, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial - transi ompleted by Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown O U		23d. Date of delivery Month Day Year
D. BC	Part il. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I. 23e	. Did tobacco use contribute to the cause of death?
ries that the signed by be detac			Yes 2 No 3 Probably 4 ✔ Unknown
Division of Vital Records, ral or Attending Physician: The law require rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should by artification: To Be Completed			Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 ✓ Yes 2 No
cian: T	25. Was case referred to medical	26.Place of Death (Check only one)	
Physic Physic ral dire	examiner? 1 Yes 2 No 1 No 1 No 28a. Date of Injury 28b. Time of Injury	DOA Other Nursing Home 28c. Injury at Work? 28d. Des	5 Residence 6 Other:
ion of tending Pheath. cath. tor: After the funeral ation: T	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	action from frigury occurred
Division o Tu the Hospital ur Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune-	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor (Specify)		ation (Street and Number or Rural Route Number, City own, State)
To the Hospital within 24 hours a To the Funeral completely filled	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the one) 2 Wedical Examiner: On the basis of examination and/or investigation, in many manner stated.		
	29b. Signature and title of certifier 29 Affler Brasney MD	O.C.M.E.	29d. Date signed (Month, Day, Year) March 10, 2011
ØV !	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Balti	more Street. Baltimore MD	21223
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	The street balance, we	
Registrar	MAD 1 5 2011 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		

Registrar

DHMH 17 Rev 7/2009

11-01898	
Jeremy Gustav Hecht	

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	State of Mar	yland /	Depa	artment	of H	lealth	and	Me	ntal	Hyg	iene

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		1- For State Registrar	Certificate o	f Death		Reg. N	0.	
Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Death Month Day		3. Time of Death
Medical Exami	ner	Jeremy (Gustav	Hecht	N.	March 10, 201	l1	0020 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locati Bowie	ion of Death	ľ	4c. County of De Prince Geo	
		3304 Saville Lane			In dea Odline In	Date of Digit (M)		<u> </u>
Funeral Director		577-80-5649	yrs. last birthday) $5.1 _{Yrs}$	Months Days Ho		1/20/1	Ea	Birthplace (State or reign Country ermany
a		Usual Residence of Decedent 10a, State 10b, County 10c.	. City, Town or Loca	tion		_		10d. Inside City Limits
ow any		MD Prince George's		owie				1 X Yes 2 No
Aaryland 28a-f show 1 at once.	호	10e. Street and Number		10f. Zip Code		110g C	itizen of What C	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	3304 Saville Lane		207	21	, og. 0		many
leath with	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X	lf \	as Decedent of Hispanic Yes, specify Cuban, Mexic			White, etc	
after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates	1	Yes 2 X No spec	cify:		Specify:	White
nours xami		15. Decedent's Education (Specify only highest grade complete		nt's Usual Occupation (G		done 16b	. Kind of Busine	ss/Industry
336 thin 72 h re. than "r	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	gainig.	Invento			Rese	arch
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. it: If item 27 is marked other than "matural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified at once	Be Cor	17. Father's Name (First, Middle, Last) Rudolf Friedrich Hec	ht			st, Middle, Maide Schnei		
21, ould b d Men	٩	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and I	Number or Rura	Route Number,	City or Town, St	ate, Zip Code)
MD d 2 shottle and the and in 27 is turn at		Michael R. Hecht/Brot						
MOFE, Pages I and the of Heal		1 Burial 2 Cremation 3 Removal from State		sition (Name of cemetery, ther place) rney crem.	3/16/		. Location - City Woodbin	·
Baltimore, permit. Pages la Department of He Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Dorota Man	rshall 22.	Name and Address of Fac Maryland Cre PO Box 1413,	<u> </u> cility emation	Service	5	
_ =====	4	23a. Part I. Enter the disease, or complications that caused the						Approximate Interval
Physician Medical		failure. List only one cause on each line.				phracory arrest, s	nock, of fical	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)		vascular Di	sease			00001
		b	100 017.					
	ě	Sequentially list conditions, if any, leading to immediate Due to (or as a consequent of the conditions).	nce of):					
	Examiner	(Disease or injury that initiated events resulting in death). Last	nce of):					
scuted and transit		events resulting in death) Last Due to (or as a consequence) d.						
a a exe	/Medical	▼ UNPENDED	,27 per m	e g913 3-18-	-11 vt			
760, ficate be ex physician the burial	Med	IF FEMALE: 23c. If yes, outcome of	pregnancy				3d. Date of deliv	rery
		23b. Was decedent pregnant in the past 12 months?		etal death 3 Ect	topic pregnancy		Month	Day Year
Box 687 e death certification at the attending ed for use as t	Physician	1 Yes 2 No 9 Unknown 9 Unknown	of death 5 0	ther (Specify)				
the dear	된	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause given in	n Part I.	23e. Did tobacc	o use contribute	to the cause of death?
P.C	<u>a</u>		3			1 Yes 2	No 3 P	robably 4 🗹 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been silted in by the funeral director, page 2 should be	Completed					24a. Was an		autopsy findings available
COT e law e e 2 sh	臣					autopsy performed	death	
tal Rec		25. Was case referred to medical		26 Place of Do	ath (Check only	1 Yes 2	No 1 🗸	Yes 2 No
Vital ysician: his certifi director,	m.	examiner? Hospital:	2 ER/Outpatient	Othor		ome 5 Resid	tence 6 🗸 Ot	her: Scene
n of V ding Phy After thi funeral d	은	27. Manner of Death 28a. Date of Injury	28b. Time of			I. Describe how in		
lon creating eath.	틸	1 X Natural 5 Pending (Month, Day, Year)		1 Yes 2	☐ No			
isic Atte er dez recto by th	igal	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	· At home, farm, stre	et, factory, office building	g, etc. 28f.	Location (Street	and Number or	Rural Route Number, City
Ital or Ital	Certification:	3 Suicide 6 Could not be determined (Specify)				or Town, State)		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in t		29a. Certifier (Check only 1 Certifying Physician: To the best of my known of the control of the	wledge, death occu	rred at the time, date and	d place, and due	to the cause(s) a	and manner as s	tated.
o the ithin	Medical	one) 2 Medical Examiner: On the basis of examinat and manner stated.	ion and/or investiga	ition, in my opinion, death	occurred at the	time, date and p	lace, and due to	the cause(s)
E ≥ E S	Me	29b. Signature and title of certifier		29c. License numb	ber	29d	. Date signed (I	Month, Day, Year)
		Aller Brosnell MB		O.C.M.E.		Ma	arch 10, 201	1
We that	ŀ	30. Name and address of person who completed cause of death	(Item 23a)					
A Bring	_	Melissa Brassell, MD Assistant Medical Exa		V. Baltimore Street,	, Baltimore,	MD 21223		
St: Regist		31. Date filed (Month, Day, Year) 32. Registrar's Si	gnature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ 10:15 P M March 11 John Mitchell Henry Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 13301 Chestnut Oak Drive Darnestown g. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 - F Days Hours Month, Day October 5 Months Mir Yrs Director 150-12-8830 85 Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Darnestown Maryland Montgomery 5 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ms 23a or must be Funeral 13301 Chestnut Oak Drive 20878 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 0 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed WWII White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Sub Contractor 12 Owner Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be ment of Health and Menta Martha McWhirter John Mitchell Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 13301 Chestnut Oak Drive, Darnestown, Maryland 20878 <u>Joan A.</u> Henry / Wife 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Park Lawn, Memorial Park = 5 1 X Burial 2 Cremation 3 Removal from State Department of Important; If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) March 16,2011 Rockville, Maryland Signature of Funeral Service Licen-Robert A. Pumphrey Funeral Home/Rockville John J. Flan 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition Pulmonary Fibrosis Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events or Attending Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Dementia, Pulmonary Embolism 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? Yes 2 X No death? 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 💢 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred XNatural injury 5 Pending work? 2 🗌 No 1 Tes Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o. within 24 hours aff To the Funeral Di Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Pragatoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

State Registrar Car1

I. 31. Date filed (Month, Day, Year

MAR 1 5 2011

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Schoenberger,

D26540

16220 Frederick Road #213, Gaithersburg, Maryland 20877

March 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Holdefer March 10^{Day} William 2011 11:17 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Edenwald Towson Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Feb. 18 Year 924 1 □**X**M 2 □ F 219-18-7755 87 MaryTand **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director ms 23a or 28a-f s must be notified Baltimore Mary land Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 U.S.A. 800 Southerly Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 XYes 2 □ No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Holdefer Gladding Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21044 19a. Informant's Name/Relationship (Type, Print) 10905 Great Oak Way David Holdefer/ Son Columbia, Maryland Baltimorė, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corporation 3/14/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck TowsonFuneral Home, Inc. 21. Signature of Funeral Service Lice 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, o mp ications that caused the death. Do not enter the mode of tyring, such as condiac or respiratory are shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 2 Be 25. Was case referred to medical Division of Vita 26. Place of Death (Check only one) Hospital Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 X Natural 5 Pending ccident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed ause of Marca 31. Date filed (Month, Day, Year) State Registrar

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David Carroll H	ubba	ard Sta 1- For State	te of Marylan	d / Depa		f Health a			ne	201	1 08079	
Physici	an/	Registrar 1. Decedent's Name (First, Middle,	Last)		inicate of	Douin		2. Da	Reg te of Death	g. No.	3. Time of Death	
Medical Exam		David	Carrol	1	Hubbaı	d		Mo Ma	nth rch 10, 2	Day Year 2011	0931 hrs	
		4a. Facility Name (if not institution,				4b. City, Town,				4c. County of Dea		
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Birector		210 00 0177	1 X M 2 F	59) Yrs			Se	Sept. 25, 1951 Foreign Marry Land			
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arylar 8a-f s	55	10e. Street and Number	IIIOI C	<u></u>	CITY III	10f. Zip Code			100	g. Citizen of What Co	untry?	
the M n or 2 tified	Director	9911 Fox Hill	Road			21	11 28			U.S.A.		
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s after	by		ced If Yes, Give Year or Dates:			Yes 2X					White	
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21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	Completed	17. Father's Name (First, Middle, L	ast)		De	resman	18.Mother's	Name (First,		aiden Surname)	r rder cov	
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MD and 2 sho saith and 2 sin 27 is	Ш	Shawn Hubbard 20a. Method of Disposition	Son	[20h [6 West	Cross		t Ba.		re, Maryla		
Baltimore, permit. Pages I an Department of Hea Important: If iter		1 Burial 2 Cremation 4 Donation 5 Other Spec	3 Removal from	State Du	ranate v or Vis		ernetery,					
timent trant:				Μe				3-14-20		Timonium	Maryland	
Bal Permi Depar Impo		21. Signature Pune of Service Li									Home, Inc.	
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/Medical		failure. List only one cause or Immediate Cause (Final disease	n each line. a. Intraoral Guns	hot Wour	nd of the He	ad					Between Onset and Death	
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876 tificat ng ph as the	3	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	ome of pregr		aldeath 3	Ectopic	oregnancy		23d. Date of delive Month	ry Day Year	
Box 68760, e death certificate by the attending physical for use as the but	Sici	1 Yes 2 No 9 Unkno	4 Pregnant a	at time of dea	-41-	er (Specify)						
that the de ned by the detached for	Physician/Me	Part II. Other significant condition	9 Unknown	th but not re	eulting in the u	aderlying cause	given in Part	1 23	e Did tobs	acco use contribute to	the cause of death?	
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Division of You the Hospital or Attending Physicial or Attending Physicial 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	<u>B</u>		ician: To the best of r									
To the comp	Medical	29b, Signature and title of certified	and manner stated		7	29c. Licen				29d. Date signed (Mo		
		2/15 V/4	2)/16	2050			.M.E.			March 11, 2011	man, Day, Fear)	
	-	30. Name and address of person wh	o completed cause of	death (Item 1	23a)							
124			Assistant Medica		•	Baltimore S	Street, Bal	timore, ME	21223			
		31. Date filed (Month, Day, Year)	32. Regist	er's Signatur	els)							
Regist	rair	MAR 15 ZUII Z	much to	. 1								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2011 MARCH 8 2:15a M CLARENCE HENDERSON Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death KESWICK NURSING CENTER BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Hours Min MARYLAND Yrs **Director** 215-14-0862 89 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 √ Yes 2 □ No MD. N/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3414 ALTO RD. 21216 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: BLACK "natural" 3 ☐ Widowed 4 🏋 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Meagne. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CITY SCHOOLS -12--6-ADMINISTRATOR BALTO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EDWARD HENDERSON HELEN FORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRUCE HENDERSON (SON) 3414 ALTO RD. BALTIMORE, MARYLAND 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) GARRISON FOREST VETERANS 3-16-2011 OWINGS MILLS, MARYLAND 4 Donation 5 Other (Specify) ee joy than d. hibnik^{2. Name and Address of Facility} REDD FUNERAL SERVICE 21. Signatu MONROE ST. BALTIMORE. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final A Physician/ Advanced MINENI disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Itiple or Attending Physician: The law requires that the death certificate be executed (eva burial-tran and Due to (or as consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital Other: 2 🗷 No 1 🗆 Yes 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 I ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Man or of Death filled in by the funeral Certificate: 28b. Time of s after death. Il Director: After t 28c. Injury at 5 \square Pending Natural work 2 🗌 No Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check only one 29b. Signature and titl 29d. Date signed (Month, Day, Year) 8854900C 3

State

DHMH 17 Rev 7/2009

Registrar

30. Name and address of per

VIJA

31. Date filed (Month, Day, Year)

ORIGINAL

N. EUTAW ST, SUITE 301, BALTIMORE MD

the completed cause of death (Item 23a) (Type, Print)

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Pegistrar's Signature

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		For State	State of Ma	ıryland					ntal Hy	gien	ne			
		Registrar 1. Decedent's Name (First, Middle, L	catl		Cer	tificate of l	Deatl			Reg. I	No.2		08081	
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Baltimore, Mosenit. Page 1 and 2 separtment of Health important: If item 27 in any injury or other transone.		20a. Method of Disposition 1 Burial 2 Cremation 3			ace of Dispos	ition (Name of atory or other place		Date			Location - C			_
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	-	30. Name and address of person who	completed cause of dear	th (Item 2	3a) (Type, Pr		<u> </u>	. Q					3 ((_
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State of Maryland / Department of Health and Mental Hygierie

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		Madonna Heritage Assi	Living		Jarretts			Hartfo	
Funeral Director		423 72 4302	x 7. Age (In 73	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan 1, 19	Year) 9	Birthplace (State or Foreign Country) TX
ryland		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
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ath v	ra	3982 Norrisville Rd.			21084				ISA
ar de tams	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
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// ATY I ATY	2	Fred A. Isgrig				Mittie Ja			
Aar 2 sh and is m		19a. Informant's Name/Relationship (T)	, , ,		ig Address (Street a				
re, Maryia s 1 and 2 should f Health and Men item 27 is marke other treumstic		Chris Isgrig Son			ountry Vill				
Saltimore, bermit. Pages 1 ar Department of Hea mportant: If item iny injury or otha 2006.		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 ★Burial 2 □ Cremation 3 ★Burial 2 □ Other (Specify)	TOTTOVAL HOTTI STATE		sition (Name of natory or other place emorial Pk			20c. Location - Cit Little Roc	k, Arkansas
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Fonds Service Licens K. Gregory Fink	M01148	22	Name and Addres		Α.		•
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the ne cause on each line.	ahon					Approximate Interval Between Onset and Death Tweek
Examiner	Jer	Sequentially list conditions,	Due to (or as a co	rsequence of):					Weeks
od / bU, icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	nsequence of):					Tyear 3 years
68 / 60, Ifficate be ex g physician as the burial	edicai		o. Parkinson	23					3 years
Geath cert death cert e attendin d for use	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
requires that the sen signed by the hould be detached.	by	Part II. Dther significant conditions co	ntributing to death but no	nt resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	,	ute to the cause of death? Probably 4 □Unknown
he la he has	Completed						24a. Was ar autops perform	y prio ned? dea	re autopsy findings available if to completion of cause of th? Yes 2 No
en: tiffica tor, p	BeC	25. Was case referred to medical				26. Place of Death		, ,	7 tes 2 NO
ystci ystci	ToB	examiner?	lospital:	2 ER/Outpatien	t 3 DOA Othe			ence 6 💆 Other	(Specify) HLF
Attanding Physicien: The lav death. sector: Atter this certificate has by the funeral director, page 2		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		28c. Injury Work			ow injury occurred	
DIVISION OF VITAL al or Attanding Physicien: T after death, I Director: After this certificat d in by the funeral director, ps	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stropecify)	eet, factory, office		28f. Location (Sti City or Town		or Rural Route Number,
To the Hospital or Attentwithin 24 hours after deall To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sicien: To the best of my ner: On the basis of exa- and manner stated.	y knowledge, death mination and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occurr	and due to the ca	ause(s) and manna ate and place, and	er as stated. If due to the cause(s)
To tha within 2 To tha comple	Me	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (#	Month, Day, Year)
->-0		1/11-1-211-	240		n	3129-		3/14/	1),
		30. Name and address of person of co	empleted cause of death	(Item 23a) (Type,	Print)	31295 Bout	20-0	/	11
		31. Date filed (Mohth, Day, Year)	mo 5 to	1 Kenus	ird Re	rout		2/260	
Sta Regista		MAR 1 5 2011	Registrar's s	A San	ed the				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month Margaret Mariko Inouye 2011 5:38 P M March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth
(Month, Day, Year)
March 30,1918 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours Min. 1 M 2XX New York Director 578-48-4120 92 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Bethesda 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6406 Hollins Dr. 20817 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3XXWidowed 4 ☐ Divorced Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Office Work Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Yanagita Minoru Kikue Katsuura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9203 Bulls Run Pkwy., Bethesda, MD Doug Farnum / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Chesapeake Crematory 3/12/2011 Beltsville, MD 21. Signature of Funeral Service Licen 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 The toluman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician/ ONE WEEK disease or condition resulting in death) ATRIAL FIBRILLATION Medical Due to (or as a consequence of) Examiner ATHEROSCLEROTIC CORONARY ARTERY DISEASE Securitinthy list provditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2XXNo Dav Year Pregnant at time of death signed by the at d be detached fo To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b DIABETES, DEMENTIA Completed 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ٩ 1 🗌 Yes 2x No 1 X Inpatient 2 -ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LOWOUS D50534 March 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 1313 Dolly Madison Blvd. #302, McLean, VA Thomas M. Masterson

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

DOYE

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 18 per th g913 3-18-11 vt. State of Maryland / Department of Health and Mental Hygiene () 08084 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jackson Jr. 03.20 PM MARCH Leon ,2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMIRE 57. AGNES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**∑** M 2□ F Months 215-28-2143 79 08 25 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Examiner must be notified at Baltimore MD NA 1 XYes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21229 U.S.A. 4242 Flowerton Road items 23a Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 , o. 1 ☐Yes 2X No Specify: Specify: Black ģ X☐ Widowed 4 ☐ Divorced "natural" Completed h and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) General Motors General Motors Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christopher Jackson Sarah Elizabeth မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 8911 Palmer Street, Ft. Washington, Md 20744 Sandra Young-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 3/21/2011 Owings Mills, Md 2). Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. In mediate Cause (Final disease or condition resulting in death) ACUTE CEREBROVASCULAR ACCIDEN dey Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE certificate has been s rector, page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 □ Yes 2 X No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1∐Yes 2XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI D0062634 MARCH (0, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATGEN AWANS HICKORY RIDGE RO COLUMBIA MO 10796 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 5 2011 Registrar

Registrar

DHMH 17 Rev 7/2009

State

			1 - State of Maryland / Dep	partment of Health and ertificate of Death	, ,	2011	08086
ı	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Kathy James	rimodio or Bodin	2. Date of Dea Month	Dav Year	3. Time of Death
	Medie Examir		4a. Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Deat Silver Sprin	th	11, 2011 4c. County of Dear Montg	
	Funeral Director		5. Social Security Number 220-60-3813 6. Sex 1 \(\text{ Number 1 M 2 \(\text{ Ne } \) } \) 7. Age (In yrs. last birthday),	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign untry) DC
	À	ro	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		/ 1932	10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Funeral Director	MD Montgomery 10e. Street and Number	Poolesvi		10g. Citizen of What Co	
	eath with tems 23a er must b	Funera	19121 Dowden Circle 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20837 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	USA 14. Race - Ame	
3036	ırs after d ural", or i Il Examin	ě	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【※Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes Give Year or Dates.	1 Yes 2 You Specify:	to Rican, etc.)	Black, White Specify: Wh	
1215-(hin 72 hou ne. t han "nat e Medica	Completed	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking	16b. Kind of Business	
ind 21	ould be filed with Mental Hygier marked other Imatic event, the	To Be C	12 17. Father's Name (First, Middle, Last) Walter Lucinski	Librarian 18. Mother's Na	me (First, Middle, M y Pech	Local Go Maiden Surname) in	vernment
Maryland 21215-0036	nd Me			ing Address (Street and Number or Ru 1 Leon Hauser]			^{o Code)} 27939
	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 20b. Place of Disp	osition (Name of matory or other place)	Date	20c. Location - City or	Town, State
Baltimore,	ermit. Pag epartmen nportant: ny injury nce.		4 Donation 5 Other (Specify) Final Jou	urney Crem. 3/1 2. Name and Address of Facility Mary Land Crei	15/2011 mation	Woodbine,	MD
	<u> </u>		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	<u>PO Box 1413,</u>	Baltim	ore, MD21	203 Approximate Interval Between
ماس	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) Acute Respir a. Due to (or as a consequence of):	atory Failure			Onset and Death
	Examiner	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury)	neumonia			
	executed an and rial-transi	dical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last c. Due to (or as a consequence of):				
09/90	ifficate be ng physici as the bu	Medica	d				
. Box o	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	ivery Day Year
S, T.	uires that the signed by the detail	þ	Part II. Other significant conditions contributing to death but not resulting in the liver Cirrosis	underlying cause given in Part I.		pacco use contribute to	the cause of death?
Records,	The law requate has been page 2 shou	Completed			24a. Was ar autops perforr 1 □ Yes	med? prior to death?	topsy findings available completion of cause of
<u> </u>	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Che			
5	ding Phy h. After this funeral d	cate: To	27. Manner of Death 12 Natural 5 Pending 28a. Date of injury (Month, Day, Year) Injury	nt 3 🗆 DOA 4 🗀 Nursing F	dome 5 ☐ Reside 28d. Describe ho	ence 6 Other (Speci w injury occurred	ify)
DIVISION	al or Atten s after deat il Director: ed in by the	Certificate:	2 ☐ Accident		28f. Location (Sti City or Town	reet and Number or Rui , State)	ral Route Number,
	ne Hospit in 24 hour ne Funera pleted fille	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred	at the time, date an	d place, and due to the d	cause(s) and manner stated.
	Tot with Total		29b. Signature and title of certifier	29c. License number D 63579		9d. Date signed (Month March 12	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Maria Tayag, M.D., 1500 For		Silver	Spring,	MD
	Stat Registra	e	31. Date filed Mooth Day Yard 11 Severe 8. Square	1			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 301 Month 6:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death pita rimore 405 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** last birthday 8. Date of Birth Days Hours Months 1 X M 2 🗆 F Vionath Day, Y Director 60 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ltimore 1 Yes 2 No 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic access. 1 🗆 Yes 2 No Specify 3 Widowed 4 Divorced Bla Year or Dates Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Be ather's Name (First, Middle, Last ٥ SYDIAN Route Number, City or Town, State, Zip Code) ostanle Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -2011 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Preumothorax disease or condition weeks Medical resulting in death) Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 626 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print 2000 abatahai 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JONES Month 1:40 AM LIAM EUGENE Marc 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL UNION BAUTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 227-30-**Director** ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tant, If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director BAUTIMORE MD1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Funeral U.S. A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) NATIONAL GYPSUM College (1-4 or 5+) other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JONES Aaron Elizabeth Mason permit. Page 1 and 2 should Department of Health and M Important; If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Murrain/DAUGHTER AVE. BALTO, MD. 21218 WYANOKE Jocelyn 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, MD GREENE FUNERAL SCUS 4 ☐ Donation 5 ☐ Other (Specify) 1201 21. Signature Funeral Service Incensee NO155 YORK ROAD. BALTIMORE, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Pulmonova Immediate Cause (Final Physician/ disease or condition resulting in death) ssthan Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine stage or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Hypertension Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Year Pregnant : Pregnant at time of death been signed by the a should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 performed hours after death. uneral Director: After this certificate I director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2X No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 📈 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimon MD21218 Hanna Union Mamorial Hospital Universita Parkwan 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per verb 9913,03/15/2011dhb trar Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 6 2011 Robert Lerov Kile Sr 6:19pm м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1213 Fourth Road Baltimore Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours May 129 1920 Baltimore, Maryland 212 14 0425 90 Director Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Baltimore County 1 Yes 2 No 10e, Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 21220 1213 Fourth Road USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify. White 3 X Widowed 4 Divorced 1943-1946 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Fireman Baltimore County Fire Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Weber Ada Beares 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1213 Fourth Road Baltimore, Maryland 21220 Earl V. Kile Sr (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State Fark Un. Meth. Ch. Cem. March 11 2011 4 Donation 5 Other (Specify) Baltimore, Maryland Majure of Funeral Service Licenses ²Lassann fighera I allome Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final つてしびに Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as bunial-transi that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cel to 457157401 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Certificate; 27. Manner of Death 28a. Date of injury 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical (Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete W. 0

DHMH 17 Rev 7/2009

State Registrar MAR 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2011 12:45 A^M Barry W. Kirschenhofer March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Belair 1215 Greystone Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** (Month, Day, av 27 Days Hours Min 1 🔀 M 2 🗆 F Yrs Director 1948 212-48-3052 62 MD May Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Belair MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21015 1215 Greystone Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Never Married 2 🔀 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Banners & Flags 12 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Schweitzer George William Kirschenhofer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1215 Greystone Rd., Belair, MD 21015 Mrs. Josephine A. Kirschenhofer∕wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State $3/15^{\circ}11$ 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Timonium, MD Dulaney Valley Memorial Gardens Donation 5 Other (Specify) yan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 0 W. Padonia Rd., Timonium, MD 21093 Bryan Part 1. Enter the disease, or complication shock, or heart failure. List only one cause sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate ause (Final Onset and Death Physician/ disease or con thron Mougn Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
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1 \sum Yes Hospital 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify, Director: After thi Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined hours after within 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tle of certifier 30. Name and address of person who completed car of death (Item 23a) (Type, Print) 7602 Belair Rd., Balto., MD 21236 Michael Zang, M.D. 31. Date filed (Month, Day, Year) State Registrar

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5 :	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Banany, etc. (c				Jily 01 101	, Gratoj		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Rea No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 20°11 4:55 Рм Joseph Carter Lampert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville Casey House Montgomery Hospice Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days Month, Day, April 17 1 🔀 M 2 🗆 F Hours Ohio Director 277-54-7757 57 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 608 Azalea Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Yes 2 No 1 Never Married 2 K Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the 4 Editor / Writer Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Daniel Lampert Betty Thelma Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Lampert / Wife 608 Azalea Drive Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State injury (4 Donation 5 Other (Specify) Final Journey Crematory 3/17/2011 Woodbine, Maryland Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M Deckrotte MO1251 ĬMD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Glioblastoma Multiforme vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 2 certificate 1 Yes 2 🗶 No Division of Vital director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: $_4$ \square Nursing Home $_5$ \square Residence $_6$ \square Other (Specify) HOSPICE 1 Tes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After i 1 X Natural 5 \square Pending n 24 hours after death. e Funeral Director: Aft leted filled in by the fur 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical within 24 hou

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completed file 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 03/14/2011 D37142 (3 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Coleman,

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

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	Physicia Medio		1. Decedent's Name (First, Middle, Last Anita P.	Lumsden				2. Date of Dea Month March	8 Day 201 Year	3. Time of Death 1:50 A. M.
	Examir		4a. Facility Name (if not institution, give	street and number)			r Location of Death		4c. County of De	ath
	Funeral		706 Orley P1. 5. Social Security Number 6. Se		last birthday)	Bela If Under 1 Year Months Days		8. Date of Birt	h QB	irthplace (State or Foreign
	Director		225-56-6871 Usual Residence of Decedent	M 2 F 72	Yrs.	Worting Baye	Tions itim.	July 1,	71938	virginia Virginia
	aryland a-f shor fied at	Director	MD 10b. County Harford		ity, Town or L	ocation				10d. Inside City Limits 1
	the Ma a or 28 be noti		10e. Street and Number	Bel	air	10f. Zip Code			10g. Citizen of What (X
	h with	Funeral	706 Orley Pl.			21014			USA	
ω.	or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🕅 No	l.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
003	urs affe :ural", al Exar	ted t	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 Yes 2 No	Specify:		Specify: Wh	ite
15-	72 ho in "nat Medica	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	edent's Usual Occup e <i>kind of work done (</i> DO NOT use retired)	eation during most of work	ing	16b. Kind of Busines	s Industry
212	within giene. er tha ; the [Elementary/Seconday (0-12)	College (1-4 or 5+) 4yrs. coll.	Teac	her			Educatio	n
and	be filed ental Hy ced oth c event	To Be	17. Father's Name (First, Middle, Last) Page Parks				18. Mother's Nam		Maiden Surname) heatley	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty)				and Number or Run	al Route Number	r, City or Town, State, 2	Zip Code)
e, N	and 2 Health tem 27 other tr		Kim Griffin- day 20a. Method of Disposition			Orley P1.		Date Date	20c. Location - City	or Town. State
mo	Page 1 nent of ant: If i		1 ☐ Burial XXXXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		ematory or other plac	ce)	- 1	Baltimore,	
3alti	permit. Departinimporta		21. Signature of Funeral Science Lic		2	22. Name and Addre	ss of Facility		610) Macphail Rd.
	40 = 60	H	23a. Part 1. Enter the disease, or comp	lications that caused the dea	ath. Do not en	Schimunek nter the mode of dyin	Funeral I	Home Of or respiratory arr	Belair Be	Lair MD 2101/
	Physician/	on v	shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	BN	TIA				Interval Between Onset and Death
مبدا	Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
		iner	Sequentially list conditions, if any, leading to immediate oduce. Enter Under Mile.	b. Due to (or as a consec	quence of):					
of 1	e executed ian and urial-transit	Examine	Cause (Disease or iinjury	c Due to (or as a consec	quence of):					
	ate be ex hysiciar the buris	dical		d						
Box 68760	certifica nding p use as t	ın/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Date of c	lelivery
. Box	he death y the afte ched for	Physician/Medical	in the past 12 mop#hs? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		☐ Ectopic pregnand ☐ Other (specify)	cy		Month	Day Year
, P.O	es that the signed by I pe deta	ρ	Part II. Other significant conditions co	ntributing to death but not re	esulting in the	underlying cause giv	ven in Part I.		obacco use contribute	to the cause of death?
ords	w requir s been s s should	Completed						24a. Was a	an 24b. Were a	utopsy findings available
Rec	The lar	Com							rmed? death?	es 2 No
ita	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:		Othe	ace of Death (Chec		-	
n of V	ding Phys h. After this funeral di	ate: To	27. Manner of Death 1. ☑ Natural 5 ☐ Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	ent 3 DOA 28c. Injun	4 ∐ Nursing Hoy y at		ence 6 Other (Spe ow injury occurred	ecify)
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be within £4 hours after death certificate be within £4 hours after death. To the Luneral Director: After this certificate has been signed by the aftending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h			163 2 110	28f. Location (S City or Tow	treet and Number or Fi n, State)	ural Route Number,
	e Hospita 124 hours e Funeral	Medical	(Check 2 Medical Examin	cian: To the best of my knowner: On the basis of examination Practioner: To the best of r	on and/or inve	estigation, in my opinio	on, death occurred a	t the time, date a	nd place, and due to the	e cause(s) and manner stated.
	To th within To th comp	~	29b. Signature and title of certifier) AA	_	29c. License			29d. Date signed (Mor	
			30 Name and address of person who co	ompleted cause of death, (Ite	m 23a) (Type,	Print)	1. N.	1,01	501	1.10
	Sta	Α	Ko (b art A. D) 31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	5 W.N	ncpm	ilka	Mal A	21014
	Registra		MAP 1 5 2011		ba	Ked	,			,

DHMH 17 Rev 1/2001

11595

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1957 New 15 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Iniversity of MD Medical Center Battimore, \mathcal{W} N/A Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 1**X** M 2 □ F Min. Jan. 12 Year 952 218-58-7818 59 **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location must be notified at Director N/ABaltimore City Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1902 Woodbourne Avenue 21239 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Black Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Administration Claims Examiner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Lewis Ellen. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Lewis Mother 1902 Woodbourne Ave., Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 03/14/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ n controlle Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2X No Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural 5 Pending injury work' 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated red cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl 5. Greene St. Ballmore, MD CRNP amar-Aclotens

Registrar DHMH 17 Rev 7/2009

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 08096 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3/14/2011 Physician/ Sandra M. Litchfield 12:05 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Transitions Health Care Sykesville Sykesville Carroll Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Months Days Hours Min. 3/12/1966 **Director** 215-02-1652 45 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔼 No MD Carrol1 Sykesville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 109 John Bennett Rd. 21784 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 XXNo Black, White, etc. 1 🛮 Never Married 2 🗆 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White marked other than "natur matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) n/a College (1-4 or 5+) and Mental Hygiene. Disabled n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Edward Litchfield Helen May Wirtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen May Litchfield/Mother 109 John Bennett Rd., Sykesville, MD 21784 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Domation 5 ☐ Other (Specify) 3/16/2011 Lake View Mem. Park Sykesville, MD Funeral Service Licknises 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Im ediate Ca se (Final dis asse or condition resulting in death) Onset and Death Physician/ Medical as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal dear 4 Pregnant at time of death 9 Unknown in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ı ∏ Yes 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4-Nursing Home 5 - Residence 6 - Other (Specify, 1 Tes 2/2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending injury work? 1 🔲 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) th (Item 23a) (Type, Print)
Rigg Road Westerninster MD 2115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALMOOD 31. Date filed (Month, Day, Year)

NAR 1 5 2011 32. Registrar's State

DHMH 17 Rev 7/2009

Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death March 12 Physician/ 2011 4:11 A M Cleta R. Lam Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Street 2304 Jerrys Road Year If Under 24 Hrs Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 XX Days Hours May 26 Day, 1923 Virginia **Director** <u> 224-16-8388</u> Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must have acted. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Street Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21154 2304 Jerrys Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Completed by Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: Specify: 3 🙀 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Be 18. Mother's Name (First, Middle, Maiden Surname)

Molly Williams 17. Father's Name (First, Middle, Last) William Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2304 Jerrys Road, Street, Maryland 21154 Donald R. Lam Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery Date 20c. Location - City or Town, State 1 xx Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/15/2011 Baltimore, Maryland 21. Signature of uneral Service License 22. Name and Address of Facility
Burgee Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Expert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine ALzheimer the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Hypothyraidism, and 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 29b. Signature and title of certifier 3/14/11

DHMH 17 Rev 7/2009

State Registrar colgate

32. Registrar's Signature

203 Forest Hill, MD 21050

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jaa

DY. AlV K 31. Date filed (Month, Day, Year)

11-01946
Dwight Milburn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	1- For State Registrar	Certif	icate of Death	Reg. No.							
Physician/	Decedent's Name (First, Midd	ent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death									
Medical Examiner	DWIGN U.K.	March 11, 2011	2214 nrs								
	4a. Facility Name (if not institution 1113 Wildwood Parkv		4b. City, Town, or Location of Death Baltimore	1 4c. C	ounty of Death						
Funeral	5. Social Security Number	6. Sex 7. Age (In yrs. last		—	/YYYY) 9. Birthplace (State or Foreign						
Director	216-54-6244 1 PM 2 F 60 Yrs. Months Days Hours Aug 25, 1960 Country Mary										
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location	•	10d. Inside City Limits						
. .	mp n	VIA B	alternore City		1 Ves 2 No						
the Maryland a or 28a-f shuw tified at once. Director	10e. Street and Number		10f. Zip Code		n of What Country?						
th the 33 or notifie	1113 Wild	wood Parkway	21229		LSA						
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygiene. Int: Witem 27 is marked other than "natural", ur items 23a or 28a-f shu ruther traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2		13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto		Race - American Indian, Black, White, etc.						
safter de iral", ur nioer mu	3 Widowed 4 Div	vorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	SA	pecify: Black						
2 hours aff "natural" Examinated by	15. Decedent's Education (Spe	ecify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		d of Business/Industry						
5-0036 ed within 72 hour bygiene. other than "natu the Medical Exam Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Auto Mechanic	/	Luta Domin						
5-00; led with tygiene other t	17. Father's Name (First, Middle		18 Mother's Name	e (First, Middle, Maiden Su	irname)						
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical To Be Comple	Robert Rand	Jolph Milburn	Ir Ma	My J. M	Mourh						
ID 21215-00; should be filed with and Mental Hygiene 77 is marked other to manife event, the Mean To Be Com	19a. Informant's Name/Relations	ship (Type, Print)	19b. Mailing Address (Street and Number or 3607 W. Forest 1		A						
P p al al	20a. Method of Disposition		ce of Disposition (Name of cemetery,		Saltic MM 21216 cation - City or Town, State						
Baltimore, Normit. Pages I and Department of Health Important: If item injury or nather frau		TAA	natory or other place) Ltro Cvernatory Ma	1911 114	moville MAD						
Baltime Department Important:	4 Donation 5 Other S 21. Signature of Funeral Service				SON SOMME						
De per	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Remarks Chayson Funeral Service 270 Prediction Paris Bald Md 2122										
Physician Medical	23a. Part I. Enter the disease, o failure. List only one cause		not enter the mode of dying, such as cardiac	or respiratory arrest, shock	Between Onset and						
xaminer	Immediate Cause (Finel disease or condition resulting in death)	a Complications of Quadrap Due to (or as a consequence of):	elegia Due to Spinal Cyst		Death						
****** (vi)	Sequentially list conditions,	b.									
iner	if any, leading to immediate Due to (or as a consequence of);										
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
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1760, ficate be executing physician and the burial - tra	IF FEMALE:	23c. If yes, outcome of pregnar	CV .	23d.	Date of delivery						
687 ertifica ding p e as th		he 1 Live birth	2 Fetel death 3 Ectopic pregn		lonth Day Year						
). Box 68° the death certification by the attending iched for use as Physician	1 Yes 2 No 9 Un	4 Pregnant at time of death Unknown	5 Other (Specify)								
O. Entre of the tacked		tions contributing to death but not resu	- 10	e contribute to the cause of death?							
xrds, P.O. * requires that the speen signed by hould be detach	<u> </u>			1 Yes 2 🗸 I	No 3 Probably 4 Unknown						
Records, I: Th. law requires ficat: has been sign, page 2 should be Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
ital Reco				performed? 1 Yes 2 ✓ No	death? 1 Yes 2 No						
tal Reichm: The certificate cector, page	25. Was case referred to medical examiner?	Unanital:	26.Place of Death (Check								
Physi ral dir	1 Yes 2 No 27. Manner of Death	I Inpatient 2 C	VOutpatient 3 DOA Other Nursi	ng Home 5 Residence 28d. Describe how injury	ce 6 Other: Scene						
Division of Vital Records, spital or Attending Physician: The law require tours after death. neral Director: After this certificate has been sir filled in by the funeral director, page 2 should b Certification: To Be Completed	1 Natural 5 Per	(Month, Day, Year)	1 Yes 2 No	Lea. Bessing flow injury	33341,54						
Vision or Attent ther death Director: in by the		estigation 28e. Place of Injury - At home	e, farm, street, factory, office building, etc.		Number or Rural Route Number, City						
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Division of Vital Records, P.O. Box 68760, The the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex		death occurred at the time, date end place, and or investigation, in my opinion, death occurred								
A S S S S S S S S S S S S S S S S S S S	29b. Signature and title of certific		29d Date signed (Month, Day, Year)								
			O.C.M.E.	Marc	March 12, 2011						
OCME	30. Name and address of perso Mary G. Ripple MD.	n who completed cause of death (Item 23 Deputy Chief Medical Examin		VID 21201							
State	31. Date filed (Month, Day, Year,	22 Pegistrar & Signatura									
Registra		Christian B. 196	ale								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10b-f. 26 per doc 9914 4-8-11 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ UELDRES MURPHY 03 35a 0 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard 5635 Columbia Road #303 Columbia 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Year) 1 06 34 Days Min. 1 M 2 X Months Hours MD Director 213-32-1057 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State with the Maryland Examiner must be notified at Director Baltimore 1 Yes 2 A No Columbia Howard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 3907 Fairview Ave items 23a or Funeral U.S.A. |5635 Columbia Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ģ 9 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 Widowed X Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) Spring Grove life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Hospital Nurse Assitant 12th grade na Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Should be file and Mental H is marked ot Gladys Smith <u>Charles E. Robinson</u> 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 5635 Columbia Road Apt 303, Columbia, Md Pamela Murphy Harris 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/21/2011 Baltimore, Md On-Site 21. Signatu of Funeral Service Licenses 22. Name and Address of Facility March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JASTRO NTESTINAL . h, sician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Year Month tor: After this certificate has been signed by the atter the funeral director, page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☑ No Day g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Tyes Yes 2 No To the Hospital or Attending Physician: | within 24 hours after death. To the Funeral Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) Be daughter's examiner? Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) residence မ 27. Manne of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed eause of death (Item 23a) Ave-BALTIMORE NO 21215 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Moove bev Physician/ Month スぴれ Medical 4a. Facility Name (if not igstitution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death Kaven Himore 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. Hours Country) Director Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 28a-f Himore Yes 2 🗌 No 23a or 2 10f. Zip Code 10g. Citizen of What Country? Wes , or items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify "natural", 3 Widowed 4 Divorced Blac Completed Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Moore Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 210 Laure Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory Dwings Mills Fores 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ancer Immediate Cause (Final Sastric Me at Pnysician/ ST a disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death this certificate has been signed by the a ral director, page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 12 Unknown ,24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 1 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred y medical 26. Place of Death (Check only one) examiner? Hospital ၟႍ 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. oause of death (Item 23a) (Type, Print) aven OUI VI JEOVA 7 State 5

Registrar

		ame	nd 1	State of M	int in larylar					and Me	Copie ntal Hy	s Ar giene	e Legible	
		Registrar 1. Decedent's Name (First,	Middle I as	t)		Cer	tifica	te of L	Death	T _a	Data of Da	Reg. N	<u> </u>	10180
Physicia Medic	al	Ruth W. Murphy					2. Date of Death Month March					1 ^{Day} 2011 ^{Year} 6:30 A M		
Examin		order control							4b. City, Town, or Location of Death Ellicott City				4c. County of Death Howard	
Funeral Director		5. Social Security Number 265–40–4396		PX 7. Ag	ge (In yrs. I 82	ast birthday) Yrs.	If Und Months	er 1 Year Days	If Under 2 Hours	24 Hrs. 8. Min. A	Date of Bir (Month, Da ug 18	th ly, Year) 19	9. Bi 028 Wash	rthplace (State or Foreign Duntry)
aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State							10d. Inside City Limits 1 ☐ Yes 2 ▼ No					
vith the Mi 23a or 28 st be noti	Funeral Director	10e. Street and Number 10f. Zip Code 8155 Cyprus Cedar Lane Unit M 21043									itizen of What C	ountry?		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hyglene. Department of Health and Mentall Hyglene. Inportant: If then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 3 🛣 Widowed 4 ☐ D	☐ Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S	li li	Yes, spe	ecify Cuba	spanic Origi n, Mexican, Specify:		Yes or No-		14. Race - Am Black, Whi	erican Indian,
Maryland 21215-0036 2 should be filed within 72 hours after this and Martal Hyglend 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed			ducation ade completed) College (1-4 or	5.1)	16a. Deced (Give k life, DO	and of we		ation Juring most o	of working		16b. l	Kind of Business	Industry
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yland Id be filed Mental H arked ot	To B	1						or's Name (First, Middle, Maiden Surname) M. McKey						
Mary, d 2 should alth and N n 27 is me er trauma		beborah Hame/Re Susan Aldaj	viship (T) • (da	pe, Print) ughter)		19b. Mailin 8155	g Addres Cypr	ss (Street a	and Number edar I	or Rural Ro Lane U	oute Numbe J nit N	r City o	r Town, State, Z licott	City MD 21043
Baltimore, semit. Page 1 and Department of Hea mportant: If item any injury or other pree.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cree 4 ☐ Donation 5 ☐ (mation 3 🗌	Removal from State		Place of Disposemetery, crem Carrol	atory or	other plac	e)	3/1	1/11		ocation - City o	r Town, State
Balt permit. Depart Import any inj once.		21. Signature of Funeral Si	vice Licens	Place									d Crema eld, MD	tory, P.A. 21784
Physician/ Medical Examiner		23a. Part 1. Enter the dise shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	ase, or comp e. List only of	a. Due to (or as	e.	h. Do not ente				ardiac or re				Approximate Interval Between Onset and Death
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3760 ficate t g physi as the t				d								_		
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours affer death. To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the		F FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	III.	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d. Date of do Month		elivery Day Year
Is, P.O.	d by P	Part II. Other significant o	onditions co	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco us							use contribute to the cause of death?			
Division of Vital Records, or a requires a flet chart. The law requires after chart. al Director. After this certificate has been signed in by the funeral director, page 2 should be a contract.	omplet											osy rmed?	prior to death?	utopsy findings available completion of cause of
al Fian: Titifical		25. Was case referred to m	edical					26. Pla	ace of Death	(Check onl	1 Yes ly one)	2 N	o <u>l</u> 1 ∐ Ye	s 2 🗆 No
Vit hysic his ce	임	1 Yes 2 No	-					sing Home	ome # Residence 6 Other (Specify)					
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Divisi tal or Att rs after do al Direct								28f. Location (Street and Number or Rural Route Number, City or Town, State)						
he Hospi in 24 hou he Funer pleted fill	Medical	29a. Certifier (Check only one) 1										cause(s) and manner stated.		
To t with		29b. Signature and title of d	certifier	\			29	c. License	number	7		29d. Da	te signed (Mont	h, Day, Year)
3		SO Name and address of p		ompleted cause of d		,23a) (Type, Pr	int)		ck	10	slui	25	15 M	1 210Y \$
Stat Registra	9	11. Date filed (Month, Day,	2011	32. Registra	ar's Signat	ure sall	,							

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 **Physician** Mary Mercorella 11:37 PM March 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Martin's Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours 060-38-7690 100 5,_ York Director Feb. 1911 New Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f show the Medical Examination ust be notified at Director 1 ☐ Yes 2 📉 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bace - American Indian. e filed within 72 hours after dual Hygiene. 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: <u></u> White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed what and Mental Hygien 7 is marked other to 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked i any Injury or other traumatic ev Luigi Girardi Assunta Manna ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Mercorella 2 Willwood Court; Baltimore, MD 21229 Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □ 🖼 oval from State New Cathedral Cemetery 3/19/2011 Baltimore, MD ◆□Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Lice 199 1630 Edmondson Avenue; Catonsville, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMONIA TWO DAYS+ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) be executed burial-transit and Due to (or as a consequence of) Box 68760, Physician/Medical or Attending Physician; The law requires that the death certificate the use as attending IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ TYPETI DIARETES MELLITUS WITH VASQUED PATHY. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSIVE CARDIOVASCULAR DISEASE CHRONIC ATRIAL24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has I page 2 s autopsy certificate FIBRILLATION, FAILURE to THRIVE. 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🕱 Natural 5 Pending investigation ours after death.

neral Director; Al
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D 29a, Certifier Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signature and title of certifier anal le Ray D0018362 3-11-2011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455, Wilkens Komal Ave. Ste LID, Baltimore, Md 2/229 K. Dang M.D

DHMH 17 Rev 1/2001

State Registrar 31, Date filed (Month, Day, MAR 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amy Juanxiu Moran State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** JUANXIU MORAN 2027 hrs March 7, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (in yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Hours 218-65-5086 2 X X 1 M 9 Country) China Yrs March 2, 2002 Usual Residence of Decedent any 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD Howard Savage permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Obepartment of Health and Mental Hygienc. Important: If item 23a or 28s-f sho important: If item 23a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 1XX Yes 2 No Director 1 23a or 28a-f e notified at o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9132 Baltimore Street 20763 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 XXNo Yes 4 Divorced If Yes, Give Yeer 1 Yes 2XX No specify. ģ Specify: Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Grade 3 Student Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Matthew Moran Rebecca Rickett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Moran father 9132 Baltimore Street Savage, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 XX Cremation 3 Removal from State crematory or other place) W. Arundel Crematory 4 Donation 5 Other Specify 3/14/2011 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 / M00770 313 Talbott Avenue Laurel, Maryla
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Maryland **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and Immediate Cause (Final disease a Head Injuries Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, ital or Attending Physician: The law requires that the death certificate be executed cian/Medical the attending physician ed for use as the burial -UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 ✓ No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available After this certificate has autopsy prior to completion of cause of performed? I ✓ Yes 2 No death? 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔲 DOA Nursing Home 5 Residence 6 Other: 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) Mar 7, 2011 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ication: 1 Natural Subject back seat passenger of auto involved in 1859 hrs Director: 5 Pending 1 Yes 2 ✔ No collision with second vehicle 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) -83 S/B MD/Pennsylvania Line @ MM 37, Parkton, MD filled determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 within 24 h Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E March 8, 2011 Dramel 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 06:50 P M Jean Gertrude Matsushige March OH 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Agnes Baltimore Moskital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) June, 27, 1934 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F 212-32-7539 76 Maryland Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eveniran must be notified at 10a. State 1 ☐ Yes 2 ☐ No Director MD Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4TH 21227 USA 316 Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2X No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Computer Operator Formulations Lenmar Laquers Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Fisher Georgia Bauman ပ္ Department of Health and Important: If item 27 is ma any Injury or other traumat once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eugene Matsushige + Husband 316 4TH Avenue Halethorpe Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Mem. Park Mar.11,2011 Sykesville Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Rome of Lansdown 21. Signature of Funeral Service Licenses he per 2719 Hammonds Ferry Road, Lansdowne MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final days **Physician** Depsi disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 X No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ∐Yes 2.2XNo 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Phospital or Attending Pi 24 hours after death. Funeral Director: After the funeral other by the funeral or by the funeral others. 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier bei Wang, M.D 2011 07 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 32. Registrar's Signature 900 Caton Ave. 31. Date filed (Month, Day, State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 011 Physician/ MARCH 6 LUCINDA McILWAIN 3:25p ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Director 214-71-1558 WASHINGTON DC 55 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director or 28a-f sh notified 1 √ Yes 2 □ No MD. ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral and 2 should be filed within 72 hours after death with Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a 210 A HILL TOP LANE 21403 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rlack. White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha DISABLED DISABILITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LIMAS McILWAIN Department of Health and Menimportant: If item 27 is marke any injury or other traumatic FRANCES JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSA SNOWDEN 1980 DOMINOE RD. ANNAPOLIS, MARYLAND 21401 20a. Method of Dis 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial ☐ Crem tion 3 Removal from State BESTGATE MEM. PARK 3-16-2011 ANNAPOLIS, MARYLAND 4 Donation 5 Other (Specify) D. HIEN R 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ neumomia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year 1 Yes 2 3 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ျှ 1 🗌 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No I Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Fractioner: To the best of my knowledge, de 29b. Signature and title of-certifier 29d. Date signed (Month, Day, Year) D 46052 rson who completed cause of death (Item 23a) (Type, Print) 2000 Medical Parkway anopolo Mp DECL 31. Date filed (Month, Day State 1 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1858 Marc Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Sinai Cit Baltmore 1stigoH Baltmore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 MM 2 🗆 F Month, Day, Months Days Hours Min. aryland **Director** Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified t 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married ☐ Yes 2 MNo Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister Pikesville 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, EMETER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility wy ederic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) GI bleed Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine for use as the burial-trans heroske cimposi that initiated events resulting in death) Last Due to for as a consequence of: Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ✓ Natural injury 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 1194043901 Mach 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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11-01975 Keith Pullen

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		- For State Certificate of Death						Reg. No.			
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Funeral		5. Social Security Number 6. S	ex 7. Age (in yrs. la	,,		f Under 24Hrs. 8. Hours Min.	Date of Birth (N	MM/DD/YYYY) 9. Birti Foreig			
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Division of Vital Records, P.O ours after death of Physician: The law requires that ours after death. Brand Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac	ifica	2 Accident Investigat 3 Suicide 6 Could not	28e Place of Injury - At ho	ling, etc. 28f	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
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To the within To the comple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License nu	ımber	29	9d. Date signed (Mo	nth, Day, Year)		
		by and	, ,,		O.C.M.E	Ξ.	V	March 13, 2011			
d		30. Name and address of person who									
Y					Baltimore, MD	21201					
S ⁱ Regis		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re .							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D20<u>11</u> Physician/ March 12, 11:45 AM Paul Charles Palumbo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 4335 Huntingtown Road Huntingtown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 1 X M 2 □ F Months Days March 22 New Jersey 82 192B Director 138-22-1126 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XX Yes 2 No Calvert Huntingtown Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20639 4335 Huntingtown Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 Specify White 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Paper Hanger Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Stefana Leone Giuseppe Palumbo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4335 Huntingtown Road Huntingtown, MD 20639 Yvonne R. Palumbo/ Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State vereity Cemetery

Veterans Cemetery 1 ABurial 2 Cremation 3 Removal from State 5 3/18/2011 Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ending physician a use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death ed by the a detached for 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. signed I ģ 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 certificate 1 Tyes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending 1 Yes within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one 3 29b. Signature and little of certifie 29c. License number 29d, Date signed (Month, Day, Year uryn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month. Day.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charlotte R. Porter March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9130 Cowenton Avenue Perry Hall Balto. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ M 2X F Months Days Min **Director** 213-34-5434 7,1936 Maryland August Usual Residence of Decedent 28a-f shov Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Md Balto. Perry Hall 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9130 Cowenton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Finance Ford Motor Credit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice E. Isennock Sarah E. Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 9130 Cowenton Avenue Perry Hall, Md. 21128 Laurie A. Behn 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State しな cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 3-14-2011 4 Donation 5 Other (Specify) Timonium, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final 10 Physician/ en disease or condition resulting in death) Medical as a consequence of LLITUS-THPE II **Examiner** APG-TE Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year been signed by the sale 1 ☐ Yes 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed? 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No injury 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who considered cause of death (Item 23a) (Type, Print) Are, Baldy MP21237 ARNI, SOHAL. M. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 03 SALVATORE Physician/ J. PERRERA 3 30 PM Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Good Samaritan Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Hours 86 April 18,1924 Maryland 219-18-7930 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Parkville Director Baltimore MD1 🗆 Yes 🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral 3508 Hiss Avenue USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify. 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)
Salesman (Specify only highest grade completed) Elementary/Seconday (0-12) 12 Self Employed College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Perrera Mary Ridolfo 19a. Informant's Name/Relationship (Type, Print) Susan Miller-daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2902 Northwind Road—Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Frankfrometer of Principles | Mar. 13, 2011 1 Burial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Evans Funeral Chapel and Cranation Services 8800 Harriord Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULM UMARY EMBOLISM Physician/ HUURS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PAYS HIP Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events MONTH physician and the burial-transit FALL Due to (or as a consequence of): APPROVED BY MEDICAL EXAMINER resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a detached f g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performe this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗌 No ဂ္ဂ 1 Impatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 2-15-2011 WNKWowW 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☑ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1909 EMMORTON RO BELAIR MD HOME Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MBBS RESODO 8 ary van 3112/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE BLVA 5301 LOCH PAVEN S.A. KOLCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:20 P M Elizabeth Jane Pyecha 11, 2011 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River Ivy Hall Geriatric Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) April 13, 1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1□M 2**점**F Maryland 69 220 36 5043 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Maryland Baltimore 1 ☐ Yes 2 🔀 No Essex 7 is marked other than "natural", or Items 23a or 28a-f sh traumatic event, the Medical Examiner must be notifiled Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 201 Middleway Rd. Apt.3C 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U S Government Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. Be Charles Pyecha Helen Washabough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charlene Thomas (Sister) 3416 Acton Rd. Baltimore, Maryland 21234 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/17/2011 Bel Air, Maryland Bel Air Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Castrointestin Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Gastric Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 X No 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes After this certificate has been si funeral director, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death. 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifie D0062194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Desai O 31. Date filed (Month, Day, Year) State MAR 15

DHMH 17 Rev 1/2001

Registrar

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· Sand	<i>*</i>		Decedent's Name (First,	Middle, Las	t)						2. Date of De	ath			3. Time of Death	
	Physici /Medic			Geza		Pely					Month March		ay Y 2011	ear	5:15 p M	
Examiner 4a. Facility Name (If not institution, give street						er)		4b. City, Town, o	r Location	of Death		40	c. County of Death			
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	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director, p.	edical				s of examina		vestigation, in my								
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	14	۲	30 Name and address of po	erson who c	1 6.4	of death (ten	11	Print) Hill CT L	atho	ro:11	e Mar	yla	nd z	00	13	
	Sta		31. Date filed (Month, Day,	Year)	32. Reg	istrar's Signa	ture	;			1	1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.							
		_	State of Maryland / Department of Health and Mental Hygiene O 1 0 8 1 4							
	Physicia Medic	al .	1. Decedent's Name (First, Middle, Last) An Finette Prittet 2. Date of Death Month Day Year 7.14 PM							
	Examin Funeral	er	4a. Facility Name (if not institution, give street and number) 2025 Hills de Dvive 4b. City, Town, or Location of Death Gwynn Oak 4c. County of Death B of Hills of B of Hills of B of B or Foreign Social Security Number 6. Sex 1 M 2 XF 7 Age (in yrs. last birthday) Yrs. 4b. City, Town, or Location of Death Gwynn Oak B of Hills of B or Foreign (Month, Day, Year) Country) MD 9. Birthplace (State or Foreign Country) MD							
	Director a-f show fied at	i. i	Usual Residence of Decedent 10a. State 10b. County Baltimore Gwynn Cak 1 ges 2 No							
h with the M	ns 23a or 28 nust be not	Funeral Director	10e. Street and Number 2025 Hillside Drive 10f. Zip Code 21207 10g. Citizen of What Country? USA							
036 Irs after deat	ural", or iten I Examiner r		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White							
21215-0036 within 72 hours after	of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12++ Qrade 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ft. Howard							
Maryland 2 should be filed	Mental Hygnarked oth	To Be	17. Father's Name (First, Middle, Last) Sylvio Panichello 18. Mother's Name (First, Middle, Maiden Surname) Helen Beach							
e, Mar	Health and Health and em 27 is n		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Ritchett / Husband 205 Hill Side Drive Gwynn Dak MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition of Disposition)							
Baltimore,	ant: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Aughn C. Greene Funeral Services							
m 8	SQ E E S		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between							
	ıysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequent of):							
e executed	To the hospital or Attending Frighting. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to finine-lists cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):							
Box 68760 are death certificate b		nysician/Medic	ysician/Medic	ysician/Medic	nysician/Medic	Physician/Medical	hysician/Medic	hysician/Medic	nysician/Medic	nysician/Medic
ds, P.O.	an signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? 1							
Records,	icate has beer, r, page 2 sho	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No							
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Division (ifter death. Virector: After in by the fune.	Certificate:	Natural 5 Pending Investigation 3 Sulcide 4 Homicide Sulcide determined (Month, Day, Year) injury work? 1 Very 1 Year Year Year Year Year Year Year Year							
D le Hospital	n 24 hours se Funeral pleted filled	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To th	withi To th	=	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 / 1 4 / 11							
	21		30. Name and address of person who completed cause of death (hem 23a) (Type Print) (of over the translation of the person who completed cause of death (hem 23a) (Type Print) (of over the translation of the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (Type Print) (of over the person who completed cause of death (hem 23a) (type Print) (of over the person who completed cause of death (hem							
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DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, way, Year)

7- .-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death QUIRK Year CATHER, NE Physician/ MARY 12:05 A MAr 7 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner GLEN BURNIE** ANNE ARUNDEL 15 ROSEDALE AVE. Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F (Month, Day, Year MAY 1, 1934 Days Hours Months Director 220 30 6905 76 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2XX No **GLEN BURNIE** ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a Funeral USA 21061 15 ROSEDALE AVE. items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 9 Yes, Give XXNo 1 ☐ Yes 2XX No 72 hours after Baltimore, Maryland 21215-0036 WHITE marked other than "natural", 3 Divorced 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL **CLERK** 2 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CATHERINE STARKEY PAUL MARTIN RAUSER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 15 ROSEDALE AVE. GLEN BURNIE, MD 2061 HUSBAND EDWARD B. QUIRK 20a. Method of Disposition

1 🖸 Burial 2 🗆 Cremation 3 🗀 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place LOUDON PARK CEMETERY BALTIMORE, MD 3.10.2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Servi F1NK FUNERAL HOME N.A. K. CRECORY FINK 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ YR NEURO MYOTONI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underly in Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Year 5 Other (specify) Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending М Investigation 6 Could not be Accident 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 00025844

State Registrar

DHMH 17 Rev 7/2009

BALAMORE

21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) MAR 15 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jacqueline Jewel Renwick Month ам March 2011 Medical 8:45 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death
Timonium County of Death Baltimore Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 214-84-4434 1 □ M 2**X** F 45 Days Hours Months Country) Director 08/10/1965 MD Usual Residence of Decedent show ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 21215 10g. Citizen of What Country? Funeral 3132 Parkington Avenue 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Force 1XXNever Married 2 Married Black, White, etc. Completed by 2 X No Baltimore, Maryland 21215-0036 72 hours after Yes marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Black 3 Divorced injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) 12 Doctor Of Chiropractice Healthcare Be permit. Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Faye Bryant James Renwick ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9111 Amber Oaks Way, Owings Mills, tamara C. Howard / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey crem. 3/15/2011 Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD2 liaismall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final .Physician/ Onset and Death BREAST CANCER Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical JACOUELINE RENWICK Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 😿 No ျှ Other; 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury 1 Yes Accident 2 No 24 hours after death Funeral Director: Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one 3 X Certifying Nurse Practioner: To the best of my knowledge at the time date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and

JACKÍE JONES,

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's signature

CRNP

92

TIMONIUM, MD 21093

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2 Date of Death Month Physician /Medical б 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) //-/3-/973 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) **Funeral** 1 MM 2 □ F 215-92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Examiner must be notified at 1 ☐ fes 2 ☐ No Director mi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 No 1 Never Married 2 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 🗸 🗸 🗸 🗸 1 🖂 þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation e kind of work done during most of working

DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surna Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Vauchan 20b. Place of Disposition (Name of certiletery, crematory of other p 20a. Method of Disposition Location - City or Town, State 1 Dourial 2 Cremation 3 Removal from State Injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Entyr e disease, or or mplication shock, or many failure. List only one control o implications that caused the death. Do not enter the mode of dying, such as call Approximate Interval Between on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 🗆 No 1 TYes certificate 25. Was case referred to medical Be 26. Place of Death (Check only one examiner Hospital: Other: 2 - ER/Outpatient 3 🗆 DOA 4 \square Nursing Home 5 \square Residence မ Inpatient 6 Other (Specify) Date of Injury

Day Year) s after death.

I Director: After this of in by the funeral of this 27. Manner of eath 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Ascident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 ☐ Homicide City or Town, State) within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March 12 ay 201 I ea Despina Roxanis 5:25 p м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F Sept 1, Year) 917 Months 93 Massachusetts Director 023-01-3298 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director MD **Baltimore** Towson 1 Yes 2 X No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21286 205 East Joppa Road, #707 death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give White 1 ☐ Yes 2X No Specify: Specify: 27 is marked other than "natural", traumatic event, the Medical Exal 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Sales of Health and Mental Hygin of Health and Mental Hygin Fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bratsos ္ပ Catherine Didris George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Dean S. Roxanis-son 7783 Rockburn Dr., Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. St. Demetrios 3/19/11 Cub Hill, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd.. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MUDDXIC resolicition Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): anding physician and use as the bunial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant atten for u in the past 12 months?

1 Yes No Month Day Year ate has been signed by the a page 2 should be detached Part II. **Other signific**an**t conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 FIVILIONES, CONGESTIVE No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an Mumaria 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2**X** No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) KelDecco lausantown 31. Date filed (Month, Day, Year) State MAR 1 5 2011 Registrar

DHMH 17 Rev 7/2009

Saltimore, Maryland 21215-0036

Box 68760

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Records,

Division of Vital

11-01919 Ersell Redd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ersell Redd		- For State	State of Maryl		artment of ertificate of		and Menta	al Hygiene	20	11 08120			
Physician	/	RegIstrar 1. Decedent's Name (First, Mid	dle,Last)					2. Date of I Month	Day Yea	3. Time of Death			
Medical Examine		ERSELL REDD 4a. Facility Name (if not institut	ion, give street and r	number)	1.	4b. City, Town	n, or Location of		10, 2011 4c. County of	" 2238 hrs			
		Maryland General Ho		,		Baltimor	е		N/A				
Funeral Director	1	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Months	Year If Under 2 Days Hours	Min	Birth(MM/DD/YYYY	Foreign			
Director	Ļ	217-38-8855 Usual Residence of Decedent	1 M 2 X F		72 Yrs		<u> </u>	7-4	-1938	Country) VIRGINIA			
, any	_	10a. State 10b. County	/	10c. City	y, Town or Locati	on				10d. Inside City Limits			
·land -f show	<u> </u>		/A		BALTIM				To an and	1 X Yes 2 No			
the Maryland a or 28a-f show tified at once.		10e. Street and Number 10f. Zip Code 10g. Citizen of 1220 OAKHURST PLACE 21216 USA							10g. Citizen of Wh				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tast: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Re Commissed by Engaged Director	3	11. Marital Status 1 Never Married 2 X		cedent Ever in to Forces?				? (Specify Yes or uerto Rican, etc.)	White	•			
s after c			ivorced If Yes, Give Ye or Dates:	ar			No specify:			BLACK			
2 hours		 Decedent's Education (Sp Elementary/Secondary (0-12 		ade completed)			upation (Give kir g life. DO NOT us		16b. Kind of Bus	siness/Industry			
5-0036 ed within 72 hour stygiene. other than "natt		-11-		0-	HO	MEMAKE	R		DOME	ESTIC			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical Commits.		17. Father's Name (First, Middle JEFFERSON BI						Name (First, Midd NIE MOORE	le, Maiden Surname) Z				
Should Berling Mer		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Address (S	Street and Number	er or Rural Route I	Number, City or Towr	n, State, Zip Code)			
and 2 sho lealth and tem 27 is traumati	2	JOYCE_REDD-I	RICE (DAUGE	20b.	Place of Dispos	tion (Name o	f cemetery,	Date	20c. Location -	RYLAND 21228 City or Town, State			
TOFE Pages ent of I-	-	1 X Burial 2 Crematic	on 3 Removal f	from State GA	crematory or oth RRISON	ier place) FOREST	VETERAN	NS ³⁻¹⁸⁻²⁰	OWINGS	MILLS, MD.			
Baltimore, permit. Pages I at Department of Hee importants: If ite injury or other tr		21. Signature of Funeral Service		HAN D.	HIBNER N	ame and Add	fress of Facility F	REDD FUNE	ERAL SERVI	CE			
Physician	12	23a. Par I. Enter the disease, of	or complications that	Saused the deat						MARYLAND 21217 art Approximate Interval			
Wedical Examiner		falure. List only one cause immediate Cause (Final diseas	e on each line.							Between Onset and Death			
zxammer	1	or condition resulting in death)	on resulting in death) Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease										
ě		Sequentially list conditions, rany, leading to immediate	Due to (or as	1 Confeduration		ase							
		cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last	C	a consequence	of):								
10, i.e.be executed ysician and bunal - transit			d										
e be ex ysician burial		UNPENDED	AMENDED						load Data of	de l'acce			
Sox 68766 death certificate e attending phy I for use as the b	2	F FEMALE: 3b. Was decedent pregnant in t past 12 months?	the 1 Live		2 Fet	al death	3 Ectopic p	regnancy	23d. Date of o	Day Year			
box 6876 The death certificate The attending phened for use as the		1 Yes 2 No 9 Ur	nknown 9 Unkr	nant at time of d nown	eath 5 Oth	ner (Specify)							
ires that the de signed by the detached for the detached		Part II. Other significant condi		to death but not	resulting in the u	nderlying cau	ise given in Part	l		bute to the cause of death?			
Records, P.(The law requires tha ficate has been signed ; page 2 should be det		Repaired right ankle	fracture		=			1 24a. W		Probably 4 Unknown Vere autopsy findings available			
Vital Records, ysician: The law requirements his certificate has been a director, page 2 should be Completee.					 			au	rformed? de	rior to completion of cause of eath?			
tal Rections The certificate ector, page		5. Was case referred to medical	al			26.P	lace of Death (CI		s 2 No 1	Yes 2 No			
Physician Physician r this certi	ш	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other ₄ N	lursing Home 5	Residence 6	Other:			
on of \ ending Physath. or: After the funeral.	. 4		nding Mar 3,	e of Injury h. Day,Year) 2011	28b. Time of Ir 0000 hrs	' ' l .	Injury at Work? Yes 2 ✓ N	Subject to		ankle between curb			
Division c spital or Attending nours after death. neral Director: Af filled in by the fun Certification		3 Suicide 6 Cou	lid not be	ce of Injury - At h	nome, farm, stree	t, factory, offi	ce building, etc.	28f. Locatio or Town		er or Rural Route Number, City			
		Oncor only	Physician: To the be aminer: On the basis	st of my knowled	dge, death occur			and due to the c	ause(s) and manner	as stated.			
To the BC within 24 To the Ru completely	2	9b. Signature and title of certifi	and manner				cense number			ed (Month, Day, Year)			
		MALL	~ X	111		0.	.C.M.E.		March 12, 2	2011			
	3	0. Name and address of person Russell Alexander MI	•	use of death (Iter Medical Exar	•	Penn Stre	eet, Baltimore	MD 21201					
State	3	1. Date filed (Month, Day, Year)		gistrar's Signat	Uros A		ot, Datanole	-, 1810 2 1 2 0 1					
Registra	r	HAD 1 5	2011 /2	arred a	8. 194	Rad		A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 11, Day 2011 Year Physician/ 8:34 Swicegood Juanita Tucker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis <u> Annapolitan Assisted Living</u> If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Hours March, Dry4 Year) 1920 North Carolina 244-18-2713 91 Director Usual Residence of Decedent ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21401 2900 Shipmaster Way #105 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever Gladys Emma Tucker Clay Tom Calloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 126 Riverton Place Edgewater, MD 21037 Bonnie Swicegood Harpole/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/19/2011 Brentwood, MD Fort Lincoln Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Dnset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner ending physician and use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown for Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other 4 Surring Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pendina ☐ Accident ☐ Suicide Investigation 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Deficed Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solomuns Is land Rol. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month March Carl Frederick Scheerer 9:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8812 Ashford Road Balto. Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country)
Maryland Days Months Hours Director 216-01-1807 93 February Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Md. Balto. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8812 Ashford Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coilege (1-4 or 5+) Draftsman Bethlehem Steel Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Jacob Scheerer Florence Purdum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR Joan Dailey 8605 Oak Road Parkville, Md. 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Meadowridge 3-17-2011 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** NO N. 15 ch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) · Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tyes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred . After (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Investigation M Accident To the Hospital or Attend within 24 hours after deat To the Funeral Director; Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 1/E Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

STIZ Newland

impleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) March Day P^{M} 9:20 2011 10 Physician Genevieve Opal Sharrer 4c. County of Death 4b. City, Town, or Location of Death /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Taneytown Lorien of Taneytown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) 6 Sex Hours 5. Social Security Number Months Days **Funeral** MD 1 M 2 X F 92 12/9/1918 215-34-5873 Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 🙀 ☐ No 28a-f show other traumatic event, the Medical Examinar must be notified at Taneytown Director Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21787 ò 2680 Crouse Mill Rd. items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Specify: White 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. Baltimore, Maryland 21215-0036 "natural", or þ 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) ne filed within 72 h tal Hygiene. **s other than "nat**u her home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lora Irene Eyler Be 1 and 2 should be fi Health and Mental I-m 27 is marked ot Charles Jessie Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14845 Barnes Rd. New Windsor, MD 21776 Marlene Black (Daughter) item 27 i 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or of once. Unionville, MD 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/13/2011 Linganore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burrier-Oueen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Fungral Service Licensee Burrier-Oueen Funeral Home a 1212 W. Old Liberty Rd. Winf with a 1212 w. on the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** diseese or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tran attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ${\Bbb C}$ Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death Year 23b. Was decedent pregnant in the past 12 months? Day 3 Ectopic pregnancy Month 5 ☐ Other (specify) 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 🗍 Unknown 1 ☐ Yes 2 ☐ No δ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes té 1 ☐ Yes certificate 26. Place of Death (Check only one Was case referred to medical examiner? director, Be Nursing Home 5 Residence 6 Other (Specify) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death After 1 Hospital or Attending 1 Natural 5 Pending investigation 2 □ No 1 ☐ Yes Location (Street and Number or Rural Route Number, City or Town, State) death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month Day, Year) 29c. License numbe 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32. Registra's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month PM Judith Karen Stallings 9:10 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT JUSEPH MEDICAL CENTER TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (in vrs. last birthday 8. Date of Birth **Funeral** Septh, Day 1 M 2XXF Days Min. Year 950 Mary Tand Months Hours 216-54-2475 60 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Pennsylvania York Delta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 150 Bair Road 17314 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ے filed wh.. خوا Hygiene. خم**r than "r** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental P 7 is marked o 2 Agnes Kremple William Owens traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau John Stallings / Husband 150 Bair Road Delta, Pennsylvania 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Evans Funeral "Chapel Mar. 4 Donation 5 Other (Specify) <u>B</u>el 2011 Forest Hill, Maryland 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill. Maryland 21050 Part in the right of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or not right failure. List only one cause on each line. Onset and Death Immediate Cause (Final KESPIRATORY Physician/ FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of Examiner PULMON ARY OBSTRUCTIVE CHRONIC Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed I funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by KENAL FAILURE 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending iniury Investigation Accident 6 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31821 m 21204 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) LINTHICKM M.D DRIVE

State Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Vital

Division of

32. Registrar's Signature

7601

OSLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ marc Judith Ann Smith 11:20PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meduca Baltimore Towson If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 □ M 2 □ Months Days Hours Country) 1946 **Director** 220-52-4039 Dec. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 🕅 Yes 2 🗌 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1821 Glen Ridge Road 21234 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Deceden. ____ Armed Forces? 1 Yes 2 No Black, White, etc 1 ▼ Never Married 2 ☐ Married ģ Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Clerk Sheltered Workshops Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic eveni 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Woodward R. Smith Norma Zeigler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Smith/mother 1821 Glen Ridge Rd., Baltimore, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Denation 5 Other (Specify) Denation 5 - Other (Specify) Paddleton Cemetery 3/12/11 Newberrytown, PA 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Funeral Movice Lice 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one dayse on each line. Approximate Interval Between Immediate Cause (Fina disease or condition resulting in death) Onset and Death Physician/ Medical Due t (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year 9 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 1 Yes 2 No 3 Probably 4 Unknown tract 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 TYes 2X No Other: |은 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at (Month, Day, Year) **X**Natural 5 Pending work? 2 No 2 Accider M Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number -10-11

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-m3:		For State Registrar	State of I	Marylan		artmen <i>tificate</i>			and M	lental Hy	giene Reg. No	2111	Annual control	08	126
	Physicia	n/	1. Decedent's Name (First, Middle, Las	,							2. Date of Death Month Day Year March 10, 2011 6:15					
والمادر	Medic	al	4a. Facility Name (if not institution, give	Roland		d Star	_		1 1'	(D 1)	March					
	Examin	er	912 Park Avenue,)		Lau:		Location of	T Death			4c. County of Death Prince George			
	Funeral		5. Social Security Number 6. Se	ex 7.7	Age (In yrs. Ia	st birthday)	If Under		If Under 2		8. Date of Bir	th	g.	Birthp	lace (State	or Foreign
	Director		220-22-9497	X M 2 □ F	82	Yrs.	Months	Days	Hours	Min.	sept I	5, rear)	.928 1	Mar	yland	
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	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number	-			10f. Zip	Code				10g. Cit	izen of Wha	t Count	try?	-
	th with ms 23 must	ner	912 Park Avenue,					707					5.A.			
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? X No	l l	Vas Deced f Yes, spec	ify Cubar	, Mexican,	in? (Spe , Puerto I	cify Yes or No- Rican, etc.)		14. Race - A Black, V Specify: W		etc.	
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121	thin 73 sne. than ne Me	E O	Elementary/Seconday (0-12)	College (1-4 o	r 5+)	life. Do	O NOT use	retired)	annig moor	0. 11 0.1	-9	C+.	ata of	· M ~	wil an	a
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lan	shoulk and N is ma auma		19a. Informant's Name/Relationship (Ty	pe, Print)	- 1	19b. Mailin	ıg Address	(Street a	nd Number	r or Rura	l Route Numbe	er, City or	Town, State	, Zip C	ode)	
ره ح	and 2 Health Sm 27 her tr		Bessie Pippenger	/ daug					Stre		Laurel					_
Baltimore,	ige 1 and of F		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		ite ce	lace of Dispo emetery, cren	natory or of	ther place			ate	l	ocation - City			-1
Ħ	nit. Pa artme ortani injury	1	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Servi ∠ Lic ns		Col	umbia					4, 11		rksvil	.те,	Mary	riand
Ba	Dep Imp any	3	Velektel milk	7	M007	73 T	onal	dson	Fune:	ral	Home, laurel,	P.A. Mary	zland	207	07-43	89
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1	Medical Examiner		resulting in death)	Due to (or a	is a conseque	ence of):										
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. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Where the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 4 Pregnant 9 Unknown	n 2 🗆 Fetal t at time of de	death 3	Ectopic p Other (sp		/				23d. Date of Month		•	Year
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la	ian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?	20.5	2000			26. Pla	ce of Death	n (Check		2 🗆 140	, , ,	103	197503	
of Vital	hysic this ce	유	1 🗌 Yes 2 🔀 No		atient 2 🗆 E				4 LJ Nur	rsing Ho	me 5 🖔 Resi	dence 6	Other (S	pecify)		
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Division	tal or Att rs after d al Direct led in by 1		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I	njury - At hor etc. <i>(Specify)</i>	me, farm, stre	et, factory,	, office		2	28f. Location (City or Tov			Rural	Route Numi	ber,
	Hosp 24 hou Funer leted fil	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examir only one 3 Certifying Nurs	ner: On the basis of	f examination	and/or invest	igation, in n	ny opinior	n, death occ	curred at	the time, date a	and place	, and due to t	the cau	ise(s) and ma	anner stated.
	Vithir To th		29b. Signature and title of certifier	411	14 /4	A		License			., 000 10 11		e signed (M			
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4			30. Name and address of person who co		,		,									
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DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 3 Year Physician/ 345 A M Marian Simmons Sawyer 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square HOSPITal Roseda Baltimore If Under Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Hours Min Maryland 03777777928 215-22-2595 82 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified Maryland Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? the Medical Examiner must be Funeral 23a 1402 Waterford Road 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married ò 5-0036 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 XXVidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working th and Mental Hygiene.
77 is marked other than traumatic event, the Me Maryland 2121 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Community College Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 be Oliver Simmons Virginia Burke and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. 1402 Waterford Road, Baltimore, Maryland 21221 Virginia Cook (Daughter) Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State emetery, crematory or other place) Holly Hill Mem. Gard. 03/15/2011 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signal Te of Funeral Several Liquid e 22. Name and Address of Facility ski Funeral Home, P.A.
Bruzdziński Funeral Home, Mary J. 1407 Old Eastern Avenue, Essex, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between nediate Cause (Final Onset and Death Phylician Arrhy Cardiac Medical resulting in death) Due to (or as a consequence of): Examiner espirator. Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a consequence of: OBSTRUCTIVE Cause (Disease or iinjury that initiated events resulting in death) Last chronic or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed' 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUERE DR md 21237 Balto DR MIChar Sule strar's Signatur State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Jr dilver March 2011 22:33 M Carver 07 Nilliam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday. **Funeral** 1 X M 2 □ F Nov. 17,1934 South Carolina Director 248-48-4458 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Director MD Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 3722 Benson Avenue 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 K Yes If Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Foreman Food Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Carver Silver Sr. Cloie Lee Bagwell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edna Silver-Wife 3722 Benson Avenue Arbutus Maryland 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition Burial 2X Cremation 3 TRemoval from State Atlantic Crematory Donation 5 ☐ Other (Specify) Mar. 11 2011 Glen Burnie Maryland Funeral Service 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Du to (or as a consequence of): disease or condition resulting in death) nepatio /Medical **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of g physician and as the burial-transit certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Year ō Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No ed by the at detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 🗌 Yes this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Residence 6 Other (Specify) မ completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural (Month, Day Year) Injury or Attending 5 Pending investigation М 2 □ No 1 🗌 Yes To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At death. 2 Accident 3
Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number March RES -000 07 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nather 600 North Wolfe St, Baltimore, MD, 21287

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 2 Date of Death 1, Decedent's Name (First, Middle, Last) Day Month March Physician/ 4:09 a M 14, 2011 Joan Shipley Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Sept 15 Days Hours Year) Country) Maryland 1 □ M 2🛣 F 1945219-44-6307 **Director** 65 Usual Residence of Decedent show 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director r 28a-f sh notified a 1 Yes 2 X No MD Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò must be r Funeral 1834 Emily Drive 21040 U.S.A. "natural", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11 Marital Status Black White, etc. 2 X No 1 Never Married 2 Married 1 Yes Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Housewife 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Alfred Stephens Margaret Stephens or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1834 Emily Drive Edgewood, Maryland Maria L. Elrod Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 3/16/2011 Sykesville, Maryland Lake View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee hen 600 Reisterstown, MD 21136 KM ELINE FUNERAL HOME Approximate Interval Between Onset and Death 23a. Part 1. Ente. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ mknom disease or condition resulting in death) Medical Due to (or as a consequan x of): Examiner utif M Know if any, leading to immediate cause. Enter Underlying Examine ANDXIC Cause (Disease or linjury the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be use as IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Dav Year Pregnant at time of death been signed by the a should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown q Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: / 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March, 14, 2011 D0065421 MD

State Registrar

0

Chesapeake Drive, BU Air, Manyland 2014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chrota fisters

31. Date filed (Month, Day, Year)
NAR 1 5 2011

500 Upper

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. 2<u>011</u> Physician/ Month March 13 6:23 p M Maureen Α. Senter Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Dove House Westminster 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth Date of Disc. (Month, Day, Year) **Funeral** Country) England 1 M 2 X F Director 212-68-3002 76 August Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Reisterstown 10g. Citizen of What Country? 10e, Street and Numbe Funeral death with 103 Fitz Court - 3 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. ð 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Whitehair Selena Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 Courtland Drive Eldersburg, MD Shelly Jordon Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Forest Lawn Cemetery 3/16/11 4 ☐ Donation 5 ☐ Other (Specify) Norfolk, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each lin in Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death To the Hospital or Attending Physician: The law requires that the death owithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death signed by the a d be detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been siç ; page 2 should b 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed' eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 \(\sum \) Yes PATHEU Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Spec 2 A No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 29d. Date signed (Month, Day, Year) nd title of certifie 29c. License number

Registrar

State

Flavio

31. Date filed (Month, Day, Year)

MAR 1 5 2011

South Center Street Westminster, Maryland

21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kruter

555

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lillian Strawder <u>11:</u>06A [™] Mar. Medical City, Town, or Location of Death Baltimore 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 1512 N. Bond St. 7. Age (In yrs. last birthday) 85 vre . Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-32-8316 1 □ M **¾**□ F Months Days Hours (Month, Day, Year Country)
MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important if item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1512 N. Bond St. 21213 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. White, etc. \$ 1 Never Married 2 Married 2 **M**No 1 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) none llth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Walter Strawder Isabell Gettings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verna Strawder(sister in-1aw) 1503 N. Wolfe St. Balto, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Oak Lawn Cem. Mar.17,2011 Balto,Md. Donation 5 Other (Specify) ature of Funeral Service Licensee Calvin Scruggs Funeral Home Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final RESPIE ATORY Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death ed by the a detached f g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown reral Director; After this certificate has been si filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 \(\sum \) Yes 2 \(\mathbb{K} \) No Hospital မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed caus

18030 E 31. Date filed (Month, Day, Year) of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:43 P M Physician/ 10ky 20年1 Jill Leslie Seitz Mayoch Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death unty of Death Baltimore Edenwald Towson 5. Social Security Number 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours 1 M 2 X F 215-42-7088 August 20 ^{an}1944 Marvland Director 66 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🗌 Yes 2 🛣 No Maryland Baltimore Towson 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 21286 800 Southerly Road items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Retail Salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Leslie Herbert Franklin Seitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 926 Cromwell Bridge Road Towson, Maryland 21286 Leslie O'Donnell/ Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hilltop Service Corporation 3/15/2011 1 Burial 2X Cremation 3 Removal from State Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 21. Signature of Funer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediat cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events Due to (or as a conseque resulting in death) Last nce of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death 1 Yes 2 detached 9 Unknown Division of Vital Records, P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ neral Director: After this certificate has been signer filled in by the funeral director, page 2 should be to 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has autonsy perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical to Titying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) the within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who ath (Item 23a) (Type, Print) 228 umorcelino 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 13 ay 20**T**I 4:30 p^{M} Schott Amelia Ruth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year
Oct. 24 . Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Mary Land Director 926 220-18-9858 84 Usual Residence of Decedent show within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21204 8416 Charles Valley Rd. #2D 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Hospital Medical Coordinator traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Andrew P. Schneider Mary Chanev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Mary Brennan/ Daughter 1308 Denby Rd. Towson, MD. 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Towson, MD. Hilltop Service Co. 3-16-11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. 21. Signature of uneral Service Acens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final PULMONALE Onset and Death COR Physician/ disease or condition Medical resulting in death) Examiner SYNDROME REST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifics the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 NOther (Specify) W S CIU 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI) Churus VARVES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 0 1 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MArch Physician/ 6300AM 2011 Augusta Bodnar Spalding Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date 3 Birth (Mostri, Day, Year) 08-30-1918 7. Age (In yrs. last birthday) Social Security Numbe Funeral 1 🗆 M 2 🕱 F Months 215-10-8289 92 Director Usual Residence of Decedent Spalding, Augusta show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 X No Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21122 1203 Holmewood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. White Yes, Give Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Peter Bodnar Eva Petrusiow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Ronald N. Spalding - Son 3 Roger Valley Court Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) 03-16-2011 Timonium, Maryland 22. Name and Address of Facility Service Licensee 21. Signature 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter medisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Uementa 4ene disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Live Birth 2 Fetal death 3 signed by the atter in the past 12 months? Month Day Year Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an after death.

Director, After this certificate has because name 2 s autops, performed? autopsy 1 🗌 Yes within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 000 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural (Month, Day, Year) 5 Pending M 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 2 MArch 13,2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Medical Center ELANCIS MD 31. Date filed (Month, Day, Year) trar's Signature State MAR 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of	Maryland		rtment of		and M	lental Hy	giene				
		Registrar	(Cer	tificate of	Death			Reg. No.		08.135		
Physic	ian/	1. Decedent's Name (First, Middle					2. Date of De Month March	ath Day 8, 2	O Year	3. Time of Death				
Med Exam		Judith Alvina T 4a. Facility Name (if not institution,		4b. City, Town,	or Location	of Death	March							
		927 Loxford Ter		Silver				4c. County of Death Montgomery						
Funera	al	5. Social Security Number		Age (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Unde	r 24 Hrs. Min.	8. Date of Bir	th	9. Birth	place (State or Foreign		
Directo	r	349-30-3598 Usual Residence of Decedent	I LI WI Z LALF	71_	Yrs.	Working	, I nound		May 5,	1939	IIIï	inois		
and show	٥	10a. State 10b. County		10c, City	, Town or Loc	ation						10d. Inside City Limits		
Maryla 8a-f	Director	Maryland Monto	omerv	Si	lver S	pring						1 ☐ Yes 2X No		
a or 2	Ξ	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	intry?		
th with	Funeral	927 Loxford Ter				20901				United	Stat	ces		
r deat	by Fu	11. Marital Status 1 □ Never Married 2 🗷 Marr	12. Was Deceder Armed Force ied 1 \(\text{Yes} \) Yes 2	s?		as Decedent of Yes, specify Cul					ce - Ameri ack, White,	can Indian, etc.		
S afte	q pe	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1	☐ Yes 2 ½ N	o Specify	/:		Specif	y: Whi	ite		
5-UU30 2 hours after "natural", o	Completed		t's Education st grade completed)	-		ent's Usual Occi		st of workir	na .	16b. Kind of I				
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d K Hygie other ent, ti	Be (17. Father's Name (First, Middle, L	4 4 ast)		Етепе	ntary S	1			Maiden Surnan		Public School		
yland Id be filed Mental Hy arked oth	P	Walter Eheim					1	ce Sha			/			
Mary 2 should th and N 27 is ma trauma	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To								r, City or Town,				
md 2; N lealth im 27		Norman Theiss /	Husband			oxford '	Cerr. S	Silve	Sprin	ıg, MD 2	0901			
ge 1 a profit of F. If ite or ot	1	20a. Method of Disposition 1 Burial 2 Cremation		ate ce	metery, crem	sition (Name of atory or other pl			ate	20c. Location	•			
DEJILIMOTE, IMARYJIANG Z1Z13-UUJ30 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annea.	t	4 Donation 5 Other (S				ney Crem						aryland		
permi Depar Impor		Devel L	Helite	MO1	දුර් 251 Be	ing Home verly L	e Cren Heck	latior crotte	n Servi e, P.A.	ce P.O. Clarks	Box ville	784 e, MD 21029		
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Date by physic the b	edical		d											
eath certifica attending pl	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon	ne of pregnan	су					23d. D	ate of deliv	/erv		
death of atter	Physician/Me	in the past 12 months? 1 Yes 2 X No	1 ☐ Live Birt 4 ☐ Pregnan 9 ☐ Unknow	t at time of de		Ectopic pregnar Other (specify)	ncy				onth	Day Year		
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es that the designed by the a	l by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Breast Cancer History 1X Yes 2 \(\text{No 3 } \) Probably 4 \(\text{Unkn.} \)												
v requires been signatured should b	etec	Dreast Califer History 1XJ Yes 2 LI No 3												
The law sate has page 2 s	Completed by								24a. Was autor perfo	osy ermed?	24b. Were autopsy findings available prior to completion of cause of death?			
ician: The certificate ector, pag	Be Co	25. Was case referred to medical	1		_	26. I	Place of Dea	ath (Check	1 Yes	2X No	1 Yes	2 🔀 No		
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ding Ph th. After th funeral		27. Manner of Death 1 X Natural 5 Pending	28a. Date of in (Month, L	njury 2 Day, Year) 2	28b. Time of injury	28c. Inju wo	'k?	_	8d. Describe h	ow injury occur	red			
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l or A after Direc	S	4 Homicide determi		etc. (Specify)	ie, rarm, stree	et, factory, office		2	City or Tow		er or Hura	l Route Number,		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	29a. Certifier 1 X Certifying (Check 2 Medical Ex	Physician: To the best	of my knowle	dge, death or	ocured at the tim	e, date and	place, and	due to the car	use(s) and man	ner as state	ed.		
the H hin 24 the Fi	Me	only one) 3 Certifying	Nurse Practioner: To the			eath occurred at t	he time, dat		, and due to the	e cause(s) and m	anner as st			
No vit		29b. Signature and title of certifier	1/	00.	A1 -	29c. Licen				29d. Date signe		Day, Year)		
, 1	1	30. Name and address of person w	the completed squee of	death (Ham	M. D) D359	996			03/09/	2011			
13		Linda Burrell 2		sity R	lvd S	uite 400) Who	itor	MD 200	02				
Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu	A. La	a. N. 9	ANTIGG	وللك	מניז עניז	VZ				
Regist	rar	MAR 1	2017 Sin	sur ,	D. 40	TIRE								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3-10-201 Pay 6:50A Medical Virginia R. Taylor 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Balto. Parkville Oak Crest Village Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 9-6-1921 Year) County 1and Director 89 217-12-6322 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b, County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No Parkville Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21234 309 N. Cardinal 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status 14 Race - American Indian. Black, White, etc. White Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Louis T. Taylor, Sr. Grace V. Groth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece 1615 Rolling road BelAir, Md. 21014 Joan R. Robertson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date cemetery, crematory or other place, □XBurial 2 □ Cremation 3 □ Removal from State 3-14-2011 Parkville, Md. Parkwood 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Schimunek FuneralHome 22. Name and Address of Facility 21236 9705 Belair road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final GIB Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year g Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure, CAD Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate 1 Yes ☐ Yes 2 🔽 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After the completed filled in by the funers 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 20a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Dav. Year) leted cause of death (Item 23a) (Type, Print) CRUP MSN 8800 Walthor Blod, Parville MD 21234 Vichealle amoon 31. Date filed (Month, Day, Year State MAR 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day :45 PM Mv'Jerah Taylor 04 March /Medical 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes HOS If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😿 F Months Davs 217-89-0178 Director 06 2010 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1 XYes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1941 Ramsey Street Funeral 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 <u>ک</u> 1 ☐ Yes 2 X No Specify Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A event, If Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked ott Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Mark Taylor Coreen Pulliam 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coreen Pulliam-Mother 1941 Ramsey Street, Baltimore, Md 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3/14/2011 Woodlawn, Md e d Funeral Service Licensee Signat 22. Name and Address of Facility
March F/H West 4300 Wasbash Ave, Baltimore, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** PULMONALE WEEKS /Medical resulting in death) Due to (or as a consequence of): Examiner LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit PREMATURITY EXTREME Due to (or as a consequence of): Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year signed by the a 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, INTRAVENTRICULAR HEMORRIHAGE 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed POST-HEMORRHAGIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy RETINOPATITI 2. No of Vital 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 □Yes 2 □No 2 Accident Director: in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aff

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year)

2

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

MD

AGNES HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOLONEY, N

11-01915 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Wilbur L. Thornton amend State of Maryland? Department of Health and Mental Hygiene 08138 2011 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Wilbur Thornton Metalical Examiner 1837 hrs March 10, 2011 Wilburt <u>Thorton</u> 4a. Facility Name (if not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death 1632 East Preston Street **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Min. Months Days Hours Director Country) 1 X M 2 F 214**-**64**-**7823 56 Yrs MD Usual Residence of Decedent 10b. County iny 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show MD NA Baltimore death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1632 E. Preston Street 21213 U.S.A. uneral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No hours after 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black <u>چ</u> r Dates: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) s 1 and 2 should be filed within 72 h of Health and Mental Hygiene. If item 27 is marked other than "n ner traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City within 72 Baltimore, MD 21215-0036 12th grade na Custodial Public Schools 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Unknown Anolta Thorton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Addie Fullter-Cousin 4808 Parkside Drive, Baltimore, Md 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If it crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify. On-Site 3/16/2011 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 2 a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 21215 Approximate Interval Md **Physician** failure. List only one cause on each line Between Onset and /Medical Atherosclerotic Cardiovascular Disease diate Cause (Final disease Examiner or candition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 841 executed attending physician and or use as the burial - trans Physician/Medical 23a,27 per me g913 3-30-11 vt 1 per me g914 4-11-11 vt X UNPENDED AMENDED The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Day 3 Ectopic pregnancy Fetal death Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? certificate Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Mursing Home 5 Residence 6 🗹 Other: Scene this 1 🗸 Yes မှ 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural Division death. Pending 1 Yes 2 No Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City hours after 3 Suicide Could not be or Town, State) determined 29a. Certifier 1 within 24 h Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ŧ one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 11, 2011 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, NAR 15 32. Registrans Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM#3 per phys, G913, 3/25/2011, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20^{Yea}l Evelvn Ferris Townsend 8:11 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing & Rehab. Center Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Feb 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral New York 1 □ M 2X\(\) 1915 Director 96 053-38-2572 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Brookeville 1¥Xyes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19109 Georgia Ave. #105 20833 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. .0 þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give "natural", White 3 X Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur aumatic event, the Medical F 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher Education Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ರ Van Dyk Emma Valtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Market St., Brookeville, MD Warren Ferris, M.D. / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory 3/10/2011 Name and Address of Facility app Funeral and Cremation Services 33 Gist Ave., Silver Spring, MD 21. Signature of Funeral M0155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death

B HOULES Immediate Cause (Final Physician/ PNEUMONIA HSPIRATION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Directo for se a nonequisione of and -transit Exam law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Dav Year Pregnant at time of death the 1 ☐ Yes ∠ ≠ 9 ☐ Unknown detached Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTIVE HEART FAILURE 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No : After this certification : Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 2 No Hospital: Other: 1 🗌 Yes 읻 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' nours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fil Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D3370U MARCH 10 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IED E. HOWE 18131 SLADE SCHOOL ED, SANDY SPRING MD 20860 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) **Physician** 2011 9:45 Talamona March 8, Gloria G. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerford Place Frederick Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 1 F **Director** 197-24-8402 79 March 11, 1931 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 🔯 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 2100 Whittier Drive 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 02 Cardiogram Technician **Healthcare** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Pages 1 and 2 should be f nent of Health and Mental i int: If item 27 is marked of ပ Michael 1 Giranda Theresa Stanziola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dino A. Talamona/Husband 9529 Fox Hollow Drive, Potomac, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 MOther (Specify) Entombment Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Signature of Fungral Service Livense Bryan W. Clary 23a. Part 1, Énter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one hause on each line.

Immediate Cause Final disease or predition resulting in death) Approximate Interval Between Onset and Death **Physiclan** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760, Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mon 3 Ectopic pregnancy 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No of Vital 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending fter death. investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated within 2 29b. Signature and the of eertifier 29c. License number D6041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen shah C Tuhnson Dr Thomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2

1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day March 4, 2011 1655 hrs romas **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 954 Forrest Street **Baltimore** If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** oreign Days Hours Director 214-84-065 Country) Maryland 1 M 2 F Yrs Usual Residence of Decedent 10d, Inside City Limits ij 10a. State 10b. County 10c, City, Town or Location 1 Yes 2 No 28a-f shnv Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", ur items 23a or 28a-7 sho Director 10g. Citizen of What Country 10e. Street and Numbe 2325 MINIS 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 1 Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year δ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) James Thomas B 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2) 19a. Informant's Name/Relationship (Type, Print) ٩ danables Thomas-20c. Location City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State Maryland LION CEMETER 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of F = ility Eureral Battimore Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a Gastrointestinal Hemorrhage complicating liver cirrhosis Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): g physician and the burial - transit Physician/Medical AMENDED 23a, pt.II, 27, per me, g917 7-7-11 sm ▼ UNPENDED Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Fetal death Year Live birth 3 Ectopic pregnancy Month Day signed by the attending I be detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Chronic Alcoholism, Hypertensive cardiovascular disease Completed After this certificate has been suneral director, page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? performed* 2 No ✓ Yes 2 No 1 🗸 Yes To the Hospital nr Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending the 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 5, 2011 O.C.M.E. OCMF (Item 2 a) 30. Name and address of person who completed cause of 0 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Stephen Edward Toms 30 AM 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospita ROSC OCIC If Under 1 Year If Under 24 Hrs. Baltimore 9. Birthplace (State or Foreign Country)
Missouri Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months **1** M 2 □ F Hours 08/08/1953 57 218-52-4007 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at MD Baltimore Director 1XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1214 Armistead Way 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2XNo Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2XTNo White þ Specify: 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Electrician Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Toms Phyllis Fian ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
367 Fletchwood Road, Apt. 48B, Elkton, MD 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau once. Zeleny / Rachael Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crem. 3/15/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Eacility
Maryland Cremation Services
PO Box 1413, Baltimore, MD21203 hashall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a.D. FFUSC Large resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examine Physician: The law requires that the death certificate be executed iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 □ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 2 Accident 1 ☐Yes 2 ☐No filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Phil Panz 31. Date filed (Month, Day, Year) 9000 Franklin Square Drive Baltimore, MD 32. Registrar's Signatu State Registrar

DHMH 17 Rev 1/2001

1 ∐Yes 2 TNo

16a. Decedent's Usual Occupation

Homemaker

Specify

(Give kind of work done during most of working life. DO NOT use retired)

 A^{M}

Specify:

Own Home

18. Mother's Name (First, Middle, Maiden Surname)

Millicent Harrison

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 Gypsy Lane, Kennett, Pennsylvania 19348

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

March 5, 2011

Year

Month

Approximate Interval Between Onset and Death

White

Funeral Director the Maryland s 23a or 28a-f show ust be notified at Pages 1 and 2 should be filed within 72 hours after death with innert of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or jury or other traumatic event, the Medical Examination is ust be no 3altimore, Maryland 21215-0036 permit. Pages Department of Important: If it any Injury or o 1 - For State Registrar

10a. State

1 □ Never Married 2 □ Married

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

3 ₩ Widowed 4 □ Divorced

Elementary/Secondary (0-12)

John Hird

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Douglas H. Taylor / Son

Director

Funeral

þ

Completed

Be

ည

Physician

/Medical

Examiner

Physician /Medical Examiner

and the burial-tran physician attending pl icate has been signed by the page 2 should be detached funeral director, this After t 24 hours after death. Funeral Director: / the filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

20b. Place of Disposition (Name of Cametery, crematory or other place)
Montgomery
Crematorium, Inc. March 11, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2011 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Function Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Myselette Bannis M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Congestive Heart Failure 1X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?

1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ₺ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D34590

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Roy E. Fried, M.D.

31. Date filed (Month, Day, Year) HAR 1 5 2011

State Registrar

completely

within 24

7758 Wisconsin Avenue #211, Bethesda, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:35 a M 2. Date of Death Physician/ March 11 Pay 2011 Year William Tilley Anthony Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 19019 Hunt Pass Court Baltimore Parkton 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ★ M 2 □ F Months Days Hours Sept. 13, 1955 125-68-0954 55 Erig Tand Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 X No Parkton 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? marked other than "natural", or items 23a o matic event, the Medical Examiner must be Funeral 19019 Hunt Pass Court 21120 United Kingdom 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Vice President Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental I permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ William Tilley .Jan Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne M. Tilley-wife 19019 Hunt Pass Ct., Parkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Hilltop Serv Corp 4 ☐ Donation 5 ☐ Other (Specify) 3/15/11 Towson, MD 21. Signature of Funeral Service William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between shock, or heart failure. List only one cause on en Immediate Cause (Final Jen Death Onset and Death Carcinoma Physician/ usdena disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 No q I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b Completed 1 🗌 Yes 3 Probably 4 Unknown No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy certificate Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 038709 30. Name and add e of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 10757

32. Registrar's Signature

Falls Rd HYIT Catherille

Shartnan

Villian

31. Date filed (Month, Day, Year)

	State of Maryland / Department of Health and Mental - For State Certificate of Death Registrar	Reg. I		08145
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Allen Robert Tepper	2. Date of Deeth Month Da March 11, 20	ay Year 111	ime of Death 0353 hrs
V	4a. Facility Name (if not institution, give street and number) Behind 7400 York Road 4b. City, Town, or Location of De		4c. County of Death Baltimore County	
Funeral Director	or operational frames.	Min. 03/31/1	MM/DD/YYYY) 9. Birthpla 932 Foreign Country	
ow any	Usual Residence of Decedent	<u>,</u>		I. Inside City Limits XYes 2 No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?	
Baltimore, MD 21215-0036 pemit. Pages I and J should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-1 she injury or other traumatic event, the Medical Examiner must be notified at sonce To Be Completed by Funeral Director	5704 Visitation Way 11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur		14. Race - American White, etc.	
ours after d	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind during most of working life. DO NOT use		Specify: White	
5-0036 led within 72 hour stygiene. other than "natu he Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Business Owner	ame (First, Middle, Mai	Sales	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. a 77 is marked other than numatic event, the Medica. To Be Comple	The factor of th	ssie	Chodak	
e, MD Stond	Nicole L. Tepper-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Baltimore Date 2	e, MD 21210 Oc. Location - City or Tow	/n, State
Baltimore, pernit. Pages I an Department of He Important: If ite	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral School Clicensee William G. Dau 22. Name and Address of Facility	Ruck Towso	Towson, MD	ome, Inc.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.	Cowson. MD	21204 , shock, or heart A	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):			Death
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C.			
) be executed ician and irial - transit dical Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			<u> </u>
760, ficate be execut g physician and s the burial - tra	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant in the	egnancy	23d. Date of delivery Month Day	Year
b. Box 68760 the death certificate by the attending physiched for use as the bhysician/Me	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
, P.O. res that the signed by the detached by PP	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes	acco use contribute to the	y 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transifiedical Certification: To Be Completed by Physician/Medical Exi		24a. Was an autopsy perform	prior to com ed? death?	sy findings available pletion of cause of
E THE TANK PARTIES AND THE PAR	25. Was case referred to medical 26.Place of Death (Ch	neck only one)		
f Vita Physicia or this ce al direc	1 Yes 2 No		esidence 6 🗸 Other: S	cene
ivision of or Attending Parter death. Director: After din by the funer-tification: 'tification: 'tification: '	27. Manner of Death 1	Subject shot s	w injury occurred self reet and Number or Rural	Deute Number City
Division or optial or Attending hours after death. uneral Director: After y filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking Lot	or Town, Sta 7400 York Road	te) d, Towson, MD	Rodie (dumber, City
To the Ho within 24 b To the Fu completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b. Sanature and title of certifier 29c. License number	red at the time, date ar	s) end manner as stated. Indicate and due to the common due to th	
	O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)		March 11, 2011	
101	Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimo	re, MD 21223		
State Registra				

11-01699
Arliss Tolbert

rliss Tolbert			ate of Maryla	•			ind Ment	tal Hy	giene	201	*	08166		
		1- For State Registrar		Ce	ertificate o	Death				eg. No.	4	3. Time of Death		
Physicia ledical Examir		1- M - 1- 1	I. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year March 2, 2011 Arliss Tolbert 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
leulcai Examii	ICI	Arliss Tolbert	on give street and n	umber)		4b City Town	or Location o	f Death	March 2, 2		Death	0600 hrs		
		Prince George's Hosp				Cheverly				Prince Ge		3		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Y	ear If Unde	r 24Hrs.	8. Date of Bir	th (MM/DD/YYYY)				
Director		578-90-6042	1M 2_XF	51	Yrs		ays Hours	Min.	06-3-1		Foreign Cour			
		Usual Residence of Decedent							00 3 1	757	_VA			
7 Any		10a. State 10b. County		10c. Cit	y, Town or Locat	ion			=		- 1	0d. Inside City Limits		
and show	ō	MD		Cap	itol Hei	aht's						1 X Yes 2 No		
Maryl 28s-1	Director	10e. Street and Number				10f. Zip Code	•		11	0g. Citizen of Wha	t Countr	y?		
the 3a or	ā	510 68th place				20743			τ	JSA				
t be n	eral	11. Marital Status 1 Never Married 2 M		cedent Ever in orces?		s Decedent of es, specify Cub				- 14. Race - White,		n Indian, Black,		
or dea	Funer		1 Yes	2 <u>v</u> No		Yes 2 X	N			0	ماء			
ural"	þ	3 Widowed 4 Div 15. Decedent's Education (Spe	orced if Yes, Give Yes or Dates:		16a. Deceder	t's Usual Occu		and of wo	rk done	SpecifyB]		lustry		
2 hou	eted	Elementary/Secondary (0-12)	College (use retire				,						
5-0036 led within 72 he stygiene. other than "n:	Completed		2+			Private	ۼ							
5-0 led wi	Š	17. Father's Name (First, Middle	Last)	First, Middle, N	/laiden Surname)		,							
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medites	Be	Charles E. Thor	arles E. Thorne: Mildred Deloris Le											
→ 등 등 := := :	ဥ	19a. Informant's Name/Relations				•				ber, City or Town,		Zip Code)		
e, MD I and 2 sho Health and item 27 is		Charles E. Tolb 20a. Method of Disposition	<u>ert/Frien</u>		110226 Place of Dispos				<u>teplair</u> Date	15,MD2069		own State		
Ore Sesting The Tree		1 Burial 2 Cremation	3 Removal fi	rom State	crematory or otl	ner place)				Landover	•	, 0.2.0		
Baltimore, permit. Pages I an Department of Hee Important: Utte		4 Donation 5 Other Statute of Funeral Service	becify:	На	rmony Me	em. Cem	etery	3-11	2011	or II Fu	•	1 Tree		
Baltimore, permit. Pages I a Department of He Umportant: If it injury or other the	Į			000 10						plains,				
Physician		23a. Part I. Enter the disease, or		aused the deat	_ V							Approximate Interval		
Medical		failure. List only one cause Immediate Cause (Final disease		ertensiv	ve Cardi	ovascu1	ar Dis	ease	:			Between Onset and Death		
Examiner		or condition resulting in death)		consequence							\neg			
	_	Sequentially list conditions, if any, leading to immediate	b.	consequence	of):						\dashv			
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cuted ind transit	Examiner	events resulting in death) Last	Due to (or as a	consequence	of):									
6 be executed ysician and burial - transit	edical	X UNPENDED	dAMENDED	23a.27	per me	g913 3-	-30-11	vt			-+			
50, te be ex aysician	P	IF FEMALE:		outcome of pre		0				23d. Date of de	elivery			
certificate	an/M	23b. Was decedent pregnant in the past 12 months?	1 Live b	oirth	2 Fe	al death	Ectopic	pregnanc	у	Month	Day	y Year		
Box 6876C e death certificate the attending phys ed for use as the bh	sici	1 Yes 2 No 9 ✔ Uni	1 ' 🗀 '	nant at time of o	leath 5 Ot	ner (Specify)				4				
the d	Physici	Part II. Other significant condit			resulting in the u	nderlying caus	e given in Par	t I.	23e. Did to	bacco use contribu	ute to the	e cause of death?		
P. S tha	<u>ā</u>								1 Yes	2 No 3	Probat	oly 4 🗹 Unknown		
cords,	Completed								24a. Was a			osy findings available		
e law e has ge 2 sk	립					-			autops	med? dea	ath?	npletion of cause of		
tal Rec		25. Was case referred to medica			-	26.Pia	ce of Death (Check on	1 Yes 2	2 NO 1	✓ Yes	2 No		
Vital hysician: this certiful director.	o Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient		Othor -			Residence 6	Other:			
4-2- 5-2	\vdash	27. Manner of Death	28a. Date	of Injury , Day,Year)	28b. Time of Ir	njury 28c. Ir	jury at Work?	2	8d. Describe h	ow injury occurred	1			
ion eath.	흹	1 X Natural 5 Pend 2 Accident Inves		,,, ,		1	Yes 2	No						
Division of ' pits or Attending Ph ours after centh. ern Director: After t filled in by the funeral	띭	3 Suicide 6 Coul	d not be 28e. Plac	e of Injury - At I	home, farm, stree	t, factory, office	building, etc.	. 2	Bf. Location (S or Town, St		or Rural	Route Number, City		
Hospital 24 hours : Funeral	Certification:	4 Homicide 29a. Certifier 1 Certifying Pl	mined (Specify)					7						
Division To the Hospita or Attent within 24 hours after cent To the Funeral Director:	ᅙ	(Check only	hysician: To the bes miner:On the basis	-	-		-					cause(s)		
To the within To the comple	Medical	29b. Signature and title of certifie	and manner s	tated			nse number			29d. Date signed				
		him h	v, n	~		0.0	.M.E.			March 3, 201	-	,		
W/ 1	-	30. Name and address of person			m 23a)									
\bigvee		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223												
Sta		31. Date flet Mantin D204	Clere 32 R	egistra s Signa	Darke									
Registi	वा	11111 = 0 == 1	7											

11-01789 Scott Tooley

	State of Maryland /	Department of Certificate of			201	0814
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) Scott Robert Tooley			2. Date of Death Month March 5, 2	Day Year	3. Time of Death 1801 hrs
ZAUGUI ZAUGUIO	Facility Name (if not institution, give street and number) 11 S Jefferson Street	-	b. City, Town, or Location of Frederick		4c. County of Death Frederick	1
Funeral Director	5. Social Security Number 2 1 3 - 2 3 - 4 6 9 0 6. Sex 7. Age ((In yrs. last birthday) 27 Yrs.	If Under 1 Year If Under Months Days Hours		0 (MM/DD/YYYY) 9. Bir 0 / 1983 Foreig Co	
W any	Usual Residence of Decedent 10a. State	Oc. City, Town or Locati				10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23s nr 28s-f show notified at once. al Director	10e. Street and Number 11 South Jefferson Street		10f. Zip Code 21701	10	g. Citizen of What Cou	
or items must be		If Y	s Decedent of Hispanic Origines, specify Cuban, Mexican, F		White, etc.	ican Indian, Black, hite
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after nert of Health and Mental Hygiene. Itan: If item 27 is marked wither than "natural", are the traumatic event, the Medical Examiner To Be Completed by	3 Widowed 4 Divorced of Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+4)	leted) 16a. Deceden during m	t's Usual Occupation (Give kinost of working life. DO NOT useral Labore	se retired)	16b. Kind of Business/	
21215-0036 uld be filed within 7 Mental Hygiene. marked niher than c event, the Medica	17. Father's Name (First, Middle, Last) Paul W. Tooley		Dia	Name (First, Middle, M nn Schmit	z	
MD 21. id 2 should buth and Mer in 27 is mar aumatic even	19a. Informant's Name/Relationship (Type, Print) Paul W. Tooley Father	19b. Mailing	Address (Street and Numb			
more, MD 2121{ ages I and 2 should be fil ent of Health and Mental It in: If item 27 is marked uther traumatic event, I	Paul W. Tooley Father 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	20b. Place of Dispos	ition (Name of cemetery,	Date 03/10/11	20c. Location - City of	Town, State
Baltimore, permit. Pages 1 a Department of the Important: If ite injury ar nther to	21. Signature of Funeral Service Licensee	Th	ame and Address of Facility OmasAllenPA	7090 Ric	dge Rd Ha	nover MD
Physician /Medical -xaminer	23a. Part I. Enter the disease, or complications that coused the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	(Heroin) In		diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the initiated	quence of):				
	events resulting in death) Last Due to (or as a conseq d.					ν
2 a isin b			per me g913 3-	-18-11 vt	Leon Date of deliver	**
6876 certificat nding physise as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at till 9 Unknown	2 _ Fe	tal death 3 Ectopic	pregnancy	23d. Date of deliver	y Day Year
. # 541 7	Part II. Other significant conditions contributing to death to	but not resulting in the t	underlying cause given in Part		bacco use contribute to	
cords law requi has been 2 should				24a. Was a autope perfor	sy prior to med? death?	utopsy findings available completion of cause of es 2 No
	25. Was case referred to medical examiner? Hospital: 1 Inpatient	t 2 ER/Outpatient	26.Place of Death (0		Residence 6 🗸 Othe	er: Scene
teath.	27. Manner of Death 1 Natural 5 Pending Investigation 1 28a. Date of Injury (Month, Day,Yea	28b. Time of lar) 11 fd 5:5	66pm 1 Yes 2 🗷	No unknow		
Division or To the Hospital ar Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune edical Certification:	3 Suicide 6 X Could not be determined (Specify)	residenc		or Town, Si Frederi	tate) 11 S. Je ck, Md.	ural Route Number, City efferson St.
Di To the Hospital or within 24 hours a To the Funeral I completely filled	one) 2 Medical Examiner: On the basis of examinant manner stated.	knowledge, death occu ination and/or investiga	tion, in my opinion, death occ	ce, and due to the causeurred at the time, date a	and place, and due to t	he cause(s)
• Ž	29b. Signature and title of certifier Wolfgatt me (Kar	el	29c. License number O.C.M.E.		29d. Date signed (Mo	orkn, Day, Year)
61	30. Name and address of person who completed cause of de Margarita Korell MD. Assistant Medical E		/. Baltimore Street, Ba	ltimore, MD 2122	3	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's NAR 1 5 2011	Signature	haw			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** P^{M} 3:00 March 10, 2011 Barbara Vines /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Nursing Home Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 ☐ M 2 🔀 F July 18, 1941 69 Ohio Director 276-36-2387 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with United States 20850 9701 Medical Center Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Specify. Specify: 2 3 ☐ Widowed 4 X Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Ford ဥ James Stroud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr any Injury or other traum once. 5901 Montrose Rd. #1103C Rockville, MD 20852 Jeaneen Searles / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 03/13/2011 Woodbine, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signatore of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) numonas **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p for use as IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place eath Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death I Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 15

Weihan Wang, MD Suite 130 15245 Shady Grove Rd Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 Year 8:00p M March Carol A. VanAlstine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1229 Reece Road Severn If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🛛 F Days (Month, Day, February Months Hours Min. Maryland Director Yrs 63 214-50-8568 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland | Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 21144 United States 1229 Reece Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Export Commodities Specialist Dept. of Ariculture Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Cyhanick Helen Gorecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8235 Reece Heights Drive, Severn, Maryland 21144 Thomas D. Harryman, II/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 14, cemetery, crematory or other place)
West Arundel
Crematory 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory Odenton, Maryland 21 MO1386 1411 Annapolis Road. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Part 1. Enter the disease, or c shock, or heart failure. List on Approximate Interval Between Onset and Death Immediate Cause (Final ⊕nysician/ Congestive Heart Failure disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to mimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2X No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available has autopsy performed? After this certificate 1 ☐ Yes 2 💢 No Yes 2 💢 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Cirector 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crain Highway, Suite 106, Glen Burnie, Maryland 21061 Wu, M.D., 1600 S. Charles

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08150 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Year Emma I. Vonella 11:35 PM ZOII march /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltemort Agnes HOSPINA 8. Date of Birth (Month, Day Ye 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year 1929 Months Days Hours Min. 1 □ M 2 👿 F 217-24-4452 Maryland 81 Director Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Modical Extrainer must be notified a once. Director Maryland | Baltimore 1 ☐ Yes 2 🕅 No Halethorpe 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1930 Bell Ave. 21227 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2√☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Clarence Hofmann Emma Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Vonella, Sr. /Husband 1930 Bell Ave., Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial March14,2011Elkridge, Maryland 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Emeral Service License 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute tailur 7 days rena disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner e to (cr. is a consequence of): unknown Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a donsequence of): attending physician Physician/Medical 350 IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Dav 5 ☐ Other (specify) the þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 a autopsy performed? certificate 2 No 1 ☐ Yes 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death

Director: A in by the f 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D5857 March 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton lao 60 wary land Lynn Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 3. Time of Death Physician/ 5:20 L. VINUP Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITA BANDMORE CITY 6. Sex 1 M 2 D F 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Days 100711 194/4931 216-28-3406 Country) MD **Director** Usual Residence of Decedent 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD Baltimore Parkville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 Funeral 1747 Wentworth Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Pyes 2 No
If Yes, Give 1952-54
Year or Dates. Black, White, et should be filed within 72 hours after of and Mental Hygiene. is marked other than "natural", or 2 1 Never Married 2XXMarried Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Electrician Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis L. Vinup Sr. Clara Matilda Weisner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1747 Wentworth Ave Parkville MD 21234 Ann Marie Vinup Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State cemetery, crematory or other pl Atlantic Crem 03/09/11 |Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Thomas Allen PA 7090 Ridge RD Hanover MD Signature of Foneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Asy smole disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** andiapul, Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sician and burial-transit that the death certificate be executed meteranic that initiated events resulting in death) Last Due to (or as a consequence of) anding physician ause as the burial-Physician/Medical Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 ☐ Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? Division 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of confifie 29d. Date signed (Month, Day, Year) D0066548 GOOD SALARITAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd Baltimore MD 21239 31. Date filed (Month, Day, Year) 2. Registrar's Sign ture State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

ielanie Ann vvi		1- For State	or Maryland /		ment of He icate of De		d Mental		201	08125
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Las	t)		.			2. Date of Death		3. Time of Death 0354 hrs
Medical Exami	ner	Melanie Ann Wilson 4a. Facility Name (if not institution, giv	e street and number)		[4b, C	ity. Town. or	Location of De	Month March 12, 2	4c. County of Death	
		19224 Circle Gate Drive				ermantow			Montgomery	
Funeral Director		5. Social Security Number 6. Security Number 11213-82-6228		(In yrs. last i 51		Under 1 Yea onths Day:		Ain. 8. Date of Birth	(MM/DD/YYYY) 9. Bird Foreig 1959	hplace (State or n untry) PA
any		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, To	wn or Location					10d. Inside City Limits
Maryiand 28a-f show d at once.	ō	MD Montgome	ry	Germa	antown					1 Yes 2xxxNo
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number 1 Bronco Ct.				Zip Code 208			g. Citizen of What Cour	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 x If Yes, Give Year or Dates:	(X) No	If Yes, s		n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black, ite
36 in 72 hours a han "natura dical Examir	ompleted by	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5-			f working life	DO NOT use	retired)	16b. Kind of Business/I	
d with	CO	12 17. Father's Name (First, Middle, Last)	2		AC		ation As 18.Mother's Na	me (First, Middle, Ma		lel gy_
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Robert N. Markovich						Ann Belch		
MD 2. nd 2 should alth and M. m 27 is m.	٩	19a. Informant's Name/Relationship (T Barbara A. Markovich	mother		7.1.	Ct., Ge	rmantown	, MD 20874	er, City or Town, State 20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hes Important: If ite		20a. Method of Disposition 1 Burial 2 X remation 3 4 Donation 5 Other Specify:		e cren	natory or other pl ington Cen	lace)		rch 18, 201		
Balti permit. Departn Imports	1	2 ature of Funeral S vice ice			Fink	and Address	1 Home,	P.A. len Burnie,	MD 21061	
Physician	2	K. Gregory Fink 23a. Port I. Ent—the lise se, ir comp fail te. List only one chase on ea	lications that caused t	he death. Do	not enter the ma	ode of dying,	such as cardia	c or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a.	Tramado1 a		etiapin	e Into	xicatio	n		Death
	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	Tuence of						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consec			-				
cuted und transit		events resulting in death) Last d.	•			_				
60, ste be exe hysician a	Medical] AMENDED 23 19a p	a,27, er fh	28a-f pe g915 5-	4-11 4	g913 3- vt	28-11 vt	Tool B to of telling	
Ox 687 ath certifica attending p		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at ti 9 Unknown		2 Fetal de	eath 3	Ectopic pre	gnancy	23d. Date of deliven Month	Year Year
P.O. Bees that the degree by the degree of detached for	by Phy	Part II. Other significant conditions		but not resul	Iting in the under	lying cause (given in Part I.		acco use contribute to	
rds, P.C requires that been signed I									24b. Were au	topsy findings available
of Vital Records, ng Physician: The law requir ther this certificate has been si meral director, page 2 should b	completed							autops perform 1 ✔ Yes 2	ned? death?	es 2 No
of Vital Re(ig Physician: The ther this certificate neral director, page	B C		lospital: 1 Inpatien	, 2 E	V/Outpatient 3	26.Place	of Death (Che		esidence 6 🗸 Other	Scene
1 of Viding Physical After this funeral directions	۱ <u>.</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	y 28	b. Time of Injury		ry at Work?	•	ow injury occurred	. Oddie
ਦ ਜ਼ਿੰ∴ `ਖੀ	ation	1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Ye		3:30 a	m 1	Yes 2 X No	unknown		
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 X Could not determined	be 28e. Place of Inju	ıry-Athome reside		ctory, office b	ouilding, etc.	28f. Location (St or Town, Sta Germant 0	reet and Number or Ruate) 19224 Ci own, Montgo	ral Route Number, City rcle Gate mery Co., M
To the Hos within 24 ho To the Fun completely	Medical ((s) and manner as stat nd place, and due to th	
F W F 3	Me	29b. Signature and title of certifier	V >			29c. Licens			29d. Date signed (Mo	nth, Day, Year)
}		30. Name and address of person who	•		,	O.C.			March 12, 2011	
		Ling Li, MD Assistant M 31. Date filed (Mapth, Day, Year)	edical Examiner		enn Street, B	altimore,	MD 21201			
S Regis	tate trar	MAR 1 5 2011		A	berel					
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Physici Med		1. Decedent's Name (First, Middle, Last) Angela Mari					2. Date of Dea		3. Time of Death
Exami		4a. Facility Name (if not institution, give street and number) Future Care Homewood			4b. City, Town, or Baltin	Location of Death		4c. County of De	ath
Funera Director		220-64-7455 1 DM 2 XF 54	ge (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 10-6		Sirthplace (State or Foreign Country)
ryland I-f show ied at	ctor	Usual Residence of Decedent 10a. State		Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
rith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 1820 Aiken Street			10f. Zip Code 21213			10g. Citizen of What	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	ed by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 M If Yes, Give Year or Dates.	Ever in U.S.	lf	Vas Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
within 72 hour jiene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12th grade College (1-4 or 1)		(Give k life. DC	lent's Usual Occup kind of work done of NOT use retired) todian	durina most of work	ing	16b. Kind of Busines	ss Industry unk
January Januar	To Be	17. Father's Name (First, Middle, Last) John McLean				18. Mother's Name		Maiden Surname)	
d 2 should alth and N 27 is ma		19a. Informant's Name/Relationship (Type, Print) Eunice McLean-Mother						r, City or Town, State,	
raith Page 1 an partment of He portant: If item y injury or othe ce.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Pla	ce of Dispos netery, crem	sition (Name of natory or other place Hill Ce	m 3-3-	Date 2011	20c. Location - City Anne Art	
permit. Departi		21. Signature of Funeral Service Licensee.			Name and Addres	ss of Facility Ma North A		ast F H Balto, i	MD 21202
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e be executed sysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as C.							
the Hospital or Attending Physician: The law requires that the death certificate be executed frin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal c	death 3 🗀	Ectopic pregnand Other (specify)	су		23d. Date of Month	delivery Day Year
v requires that the des been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death t	out not result	ting in the u	nderlying cause giv	ven in Part I.	- 1		to the cause of death? Probably 4 Unknown
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Attending Physician: The lart death, ector: After this certificate hay the funeral director, page		27. Manur of Death 1 Natural 5 Pending (Month, Date of injugation) 2 Accident Investigation	ury 2	8b. Time of injury	28c. Injury	y at		now injury occurred	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fun	Il Certificate:	3 Suicide 6 Could not be 28e. Place of Inj	ury - At hom c. (Specify)	e, farm, stre	eet, factory, office		28f. Location (\$ City or Tov	Street and Number or i vn, State)	Rural Route Number,
he Hospii in 24 hou he Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of 6 only one) 3 Certifying Nurse Practioner: To the	examination a	and/or invest	igation, in my opinio	on, death occurred a	t the time, date a	and place, and due to the	e cause(s) and manner stated.
To t with		29b. Signature and title of certifier			29c. Licenso	7727	- 1	29d. Date signed (Mo	nth, Day, Year)
3		30. Name and address of person who completed cause of o	8813	3a) (Type, P	Man	Wood	blo	od. M	121234.
Sta Regist	ate rar	31. Date filed (Month Day Year) 5 2011 32 flegistr	ar's Signatur	1. 40	ale				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Dwight Carroll Woolridge 7:06 PM MARCH 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Nov 24, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral** Year) 1 X M 2 □ F 68 Yrs. Director 214-40-1677 1942 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, Ing Medical Examiner must be notified at 1XYes 2 No Director MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2968 Bero Road 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married XYes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No ģ Specify. 3 Widowed 4 Divorced White Vietnam Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Roofer Residential 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hubert Clyde Woolridge Anna Eugena Keene ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Colleen Karcher /Sister 27 1105 Sulphur Spring Road Halethorpe, MD 21227 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of Important: If it any injury or concept to the concep 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State Mar 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Nacrementation and Funeral Alternatives Kebac 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician NEUMONIA disease or condition resulting in death) 7 c/a /Medical Due to (or as a consequence of): Diseaso Examiner END STAGE 1 MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ⊒Yes 2 □ No o 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an page 2 autopsy 2 No Vital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 217No 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA ot funeral 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending investigation 1 h If latural death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 S CATON AVENUE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AR 15.2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Martha Burling Whitmore March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20 Woodmoor Drive Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 2, 1917 1 □ M 2√X F Days Min. Months Hours **Director** 94 Yrs 218-52-8456 Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f shower, the Medical Examiner must be notified at 10c. City, Town or Location Director MD Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Woodmoor Drive 20901 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Kremers Margaret Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan H. Whitmore / Daughter 20 Woodmoor Drive, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory ! 3/13/2011 Beltsville, MD Signature of Funeral Service Licensee 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 M00382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ysician a e burial-1 Physician/Medical Box 68760 attending physi I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, Completed ADULT FAILURE TO THRIVE SYNDROME 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv page certificate Yes the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2XX No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 5 Pending injury X Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinating and/or inventioning in a number of the cause of examinating and/or inventioning in a number of the cause of examinating and/or inventioning in a number of the cause of examinating and/or inventioning in a number of the cause of examinating and/or inventioning in a number of the cause of the cause of examinating and/or inventioning in a number of the cause of examinating and/or inventioning in a number of the cause of examinating and/or inventioning in a number of the cause of examinating and/or inventioning in a number of the cause of examinating and/or inventioning in a number of the cause of examinating and/or inventioning in a number of examinating and or inventioning in a number of examinating in a number of examin 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) MARCH 11, 2011

20910

1 Yes 2 No

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 🗆 Yes 2 🔀 No

11:15 A^M

201^{Year}

Montgomery

Black, White, etc.

White

Burling

20901

Interval Between Onset and Death

New York

State Registrar

31. Date filed (Month, Day, Year MAR 1 5 2011

29b. Signature and title of certifier

whert

1500 FOREST GLEN RD., SILVER SPRING, MD ROBERT H. GERARD M.D., 32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

D0055522

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex (In vrs. last hirthday) **Funeral** Director with the Maryland Od Inside City Limits 10b. County 10c. City, Town or Location 28a-f show aţ ender Director 1 ☐ Yes 2 ☐ No "natural", or items 23a or 28a-f s idical Examiner must be notified 10g. Citizen of What Country? Funeral Pages 1 and 2 should be filed within 72 hours after death 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Baltimore, Maryland Be 19b. Mailing Address (Street and Number item 27 Method of Disposition Burial Department of Important: If it any injury or o once. 2 Cremation 5 Other (Specify) 21. Signature of Funeral Se 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter Approximate shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) HYPERTENSIVE Physician CARDIOMYOPATHY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any leading to translation cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death
9 Unknown 5 Other (specify) ate has been signed by the at page 2 should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X NO 1 Tyes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 2 No 1X Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence ဂ္ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director; After 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 29b. Signature and title of certifier 29c. License number RES-000 MARCH 10,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 MIKHAILIA LAKE MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2011 March Margaret Elaine Webb 11:47A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1617 Four Georges Ct. Apt. B3 Dunda1k Baltimore Co. 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours (Month, Day, Year) Maryland 1 M 2X F Director 219-46-1762 May Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Dunda1k ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 1617 Four Georges Court Apt. B3 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Waryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) 12 Years Custodian Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jerome Curtin Margaret Stella Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Eugene V. Webb (Husband) 1617 Four Georges Court Apt. B3 Dundalk, MD 21222 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Hilltop Service Corp 4 ☐ Donation 5 ☐ Other (Specify) 3/14/2011 Towson, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 21. Signam 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) OMPI ications Medical Examiner Due to r as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 2X No 1 Yes 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner?
1 Yes Hospital: Other: 2 No မ 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural Accident 5 Pending 2230 P tal 1 Yes 2 No 01/2011 Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Pural Route Number, City on Town, State) 1017 Fow Genzes Count Dunda K, Maryland 2122 filled in by 4 Homicide determined Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 8,2011 30. Name and address of perwho completed cause of death (tem 23a) (Type, Print) (rumb egistrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per fh e913 3-15-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician /Medical 01 Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Days 10 1 🗆 M 2 🕟 Hours Min March 21, 2010 Director 11 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location show 10h County ral", or items 23a or 28a-f sho Examiner must be notified at 1 Ves 2 □ No Funeral Director MI Elliott City 10Wato toward 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? ver errace 32 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 VIO If Yes, Give Year or Dates Specify <u>გ</u> Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be and Mental NOK 400 00 00 ပ Or 19a. Informant's me/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a <u> 32</u> erraco Pages 1 20b. Place of Disposition (Name of gemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If ite any Injury or ott 1 Burial 2 Cremation 3 Removal from State 5/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signatuz of Funeral Service Licensee Hoxue once Ju Kol Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final taille piratoru **Physician** disease or condition resulting in death) /Medical r as a consequence of) Due to Examiner uria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran and PROVED BY MEDICAL EXAMINER Due to (or as a consequence of): attending physician of for use as the buris Box 68760. Physician/Medical IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy Yes 2 No 9 Unknown in the past 12 months? Month Day Year 5 Other (specify) P.O. I Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🗌 No Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 6 - Other (Specify) 5 Residence မ After this 28d. Describe how injury occurred accident where venetian blinds wroughed around new paping x (28t. Location (Street and Number of Revene Number) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: Injury 11 30 the Hospital or Attending 1 🗌 Natural 5 Pending investigation (Month, Day 105 A M 1 Tyes 2 No death. 2 Accident 03 hours after death 3 Suicide 6 Could not be determined lace of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. 4 - Homicide 8,50 Randolph way Columbia, M. Home in livingroom 21042 within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ Da 2 30. Name and add ress of person who completed cause of death (Item 23a) (Type, Print) Elizabetch 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 Young-Wyatt 2011 10:42a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchirst Hospice Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 X F Months Days Hours Min (Month, Day, Year) Director 213-60-2471 09 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location ıral", or items 23a or 28a-f sho I Examiner must be notified at Director 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 804 Wedgewood Road 21229 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Veteran Medical life. DO NOT use retired) Elementary/Seconday (0-12)
2th Grade College (1-4 or 5+) 4yrs Registered Nurse Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Donald Young Lucy Tittf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andre Wyatt-Husband 804 Wedgewood Road, Baltimore, Md 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 3/14/2011|Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, ala Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death olan Physician/ disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death been signed by the should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by momboembolic delest Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 \square Nursing Home 5 \square Residence \lozenge Other (Specify) VCC \trianglerighteq OTHER ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) March 11 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 670 IN Charles ST ~ powsen un 31. Date filed (Month, Day, Year) State MAR 1

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19, 2011 0445 February John M. Adams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 D F Min. (Month, Day, Year) Mary Land Months Days Hours Director 214-28-4785 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Washington DC 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral United States 1434 18th Street SE 20020 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🔀 No Specify: "natural". 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic account. 12th Private Pepco Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Gertrude Hawkins John Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandywine, Maryland Rodney Adams - Son 12112 Elmwood Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland 4 Donation 5 Other (Specify) Lincoln 22. Name and Address of Facility Stewart Funeral Home, 21. Sig ature of Funerat Service Libense 4001 Benning Road NE Washington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying nding physician and use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe Yes 2 XN To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Npatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19-2011 · Chandrasellew MD52855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenbelt, Maryland

State Registrar DHMH 17 Rev 7/2009 Chandra S. Korapati,

2011

31. Date filed (Month, Day, Year,

MD

32. Registre's Sign

7207-B Hanover Parkway

			1 - For Amend Registrar	Item 1	State o	f Maryla	nd/Dep 03/28/2 <i>Cel</i>	ortment of 1 dhb	of Healt of Deat	th and I h	Mental Hy	/giene2	011	08161
	Physicia		1. Decedent's Name (Fi		ad Men	doza C					2. Date of D Month Feb.	eath Dav	Year 011	3. Time of Death 3:00 P M
made	Medio Examin		4a. Facility Name (if not					4b. City, Tov	n, or Locat	ion of Death			unty of Deat	1
and of			11301 Norr	is Drive	9			Silv	er Sp	ring		Mo	ntgome	ry
	Funeral Director		5. Social Security Numb None	1 [х _ M 2 🕱 F	7. Age (In yrs	last birthday) 77 Yrs.	If Under 1 \ Months D	ear If Ur ays Hou	nder 24 Hrs. rs Min.	8. Date of B (Month, D	ay, Year)	Cot	hplace (State or Foreign Intry) ivia
	ld now at	L	Usual Residence of Dec 10a. State 10	cedent b. County		100.0	City, Town or Lo	cation						10d. Inside City Limits
	a-fst fieds	cto	MD		gomery			er Spr	ing					1 ☐ Yes 2 🍱 No
	the Ma or 28	Funeral Director	10e. Street and Number	er				10f. Zip Co					of What Co	untry?
	s 23a nust b	nera	11301 Nor	ris Dri	7e			20902				Bol:	ivia	
920	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 3 ☒ Widowed 4 ☐		12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	rces? 2 ½ No e		Vas Decedent f Yes, specify (Cuban, Mex	cican, Puerto	ecify Yes or No Rican, etc.) Bolivi	an	Race - Ame Black, White ecify:	
Maryland 21215-0036	iled within 72 hou I Hygiene. other than "nati rent, the Medica	Completed by	(Specify Elementary/Seconda	5. Decedent's Ed only highest gra lay (0-12) 12			(Give	dent's Usual O kind of work do O NOT use ret emaker	ne during r	nost of worl	king		of Business wn Hom	
land ;	should be filed v h and Mental Hyg is marked othe traumatic event,	To Be	17. Father's Name <i>(First</i> Miguel M								ne (First, Middle	e, Maiden Sun	name)	
ary	hould and M is mai	- 13	19a. Informant's Name		oe, Print)		19b. Mailir	ng Address (St			ral Route Numb	er, City or Tov	vn, State, Zip	Code)
	nd 2 s ealth n 27 i		Vivian S.		ama/Dau	ghter	1130	1 Norr	is Dr	ive, S	Silver	Spring	, MD 2	0902
Baltimore,	permit. Page 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked or any injury or other traumatic everone.		20a. Method of Disposit 1 ☐ Burial 2X 0 4 ☐ Donation 5 [Cremation 3 🗌		State	. Place of Dispo cemetery, cren [etropol	natory or other	place)	ory F	27,	1	ion - City or andria	
Balt	permit. Departi Import any inji	19	21. Signature of Funera	al Service License	foto	Mo	1503 Fr	Name and A	dress of Fa J. Co. ersit	ility 11ins y B1vo	Funera	1 Home ilver	Inc. Spring	,MD 20901
	h sician/	e (6	23a Part 1. Enter the c shock, or heart fai Immediate Cause (Fina disease or condition	illure. List only or	e cause on ea	caused the de ch line. Cancer	ath. Do not ente							Approximate Interval Between Onset and Death 3 mos.
مبرا	Medical Examiner		resulting in death)	ſ	a	or as a conse								0 11001
	hed nsit	Examiner	Sequentially list conditi if any, leading to immed cause. Enter Underlying Cause (Disease or iinju	ng 🔣	b. — Due to (or as a conse	quence of):							
0	cate be executed physician and sthe burial-transit	edical Exa	that initiated events resulting in death) Last	· L	C. Due to (or as a conse	quence of):							
3760	ficate g phy as the		IS SEMALO											
. Box 687	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-trans.	Physician/M	IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	nths?		Birth 2 ☐ Fe nant at time o	etal death 3	Ectopic preg Other (specif				23d	l. Date of del Month	ivery Day Year
s, P.O.	ires that the dea signed by the a Id be detached f	by	Part II. Other significar	nt conditions co	ntributing to d	eath but not r	esulting in the u	nderlying caus	e given in F	Part I.				the cause of death?
ord	require been si should I	lete									24a. Wa:	an 2		topsy findings available
3ec	he law te has	Completed									per	opsy formed? 2 🙀 No	death?	completion of cause of
a	ian: T irtifica ctor, p	Be C	25. Was case referred to examiner?	o medical				2	6. Place of	Death (Chec		2 <u>A</u> 2 NO	1 🗀 103	2
Σ	hysic his ce	욘	1 Yes 2 🖰 No	o F	lospital:	Inpatient 2	☐ ER/Outpatier		Other: 4 [Nursing H	ome 5 Res	idence 6 🗆	Other (Spec	ify)
on of	ending P sath. or: After t he funera	Certificate:	2 Accident	Pending Investigation	28a. Date (Mont	of injury h, Day, Year)	28b. Time of injury		njury at work? I □ Yes 2	2 🗌 No	28d. Describe	how injury oc	curred	
Division of Vital Records,	tal or Att rs after d al Directo ed in by t		3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place buildir	of Injury - At I ng, etc. <i>(Spec</i>	home, farm, stre ify)	eet, factory, of	ice			(Street and No wn, State)	ımber or Rui	ral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 🔲	Certifying Physi Medical Examir Certifying Nurse	er: On the bas	is of examinati	ion and/or invest	igation, in my o	pinion, deat	th occurred a	at the time, date	and place, and	d due to the o	cause(s) and manner stated.
	Vith vith COM		29b. Signature and title		uu Ck	INP		_	ense numb			29d. Date si	gned (Month	, Day, Year)
			30. Name and address of the lichelle Tu	of person who co	empleted caus CRNP	e of death (Ite 22 S	m 23a) (Type, P outh Gr				imore,	MD	•	
	Stat Registra		31. Date filed (Month, Da	ay, Year)	32. R	egistrar's Sigr	nature from	12						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Day Pierre-Michel а Brice 2011 .20 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. (Month, Day, Yea 578-72-7449 78^{Yrs} **Director** June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location death with the Maryland Director MD Montgomery 1 Yes 21 No Silver Spring 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? Funeral USA 3308 Hampton Point Drive, Apt. D 20904 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Specify: Black Black White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examino once. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ĀNo Specify: If Yes, Give Year or Dates 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jeanne Sully Edgard Pierre-Michel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8270 Wellington Place, Jessup, MD 20794 Alix Brice, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3/5/11 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Cardiac Arrest Medical **Examiner** Respiratory Failure Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of signed by the attending physician and Coronary Artery Disease To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed peen . Were autopsy findings available prior to completion of cause of 24a, Was an this certificate has performed? Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) Feb. 25, 2011 29b. Signature and title of certifier 29c. License number D66249 m.D.

Registrar
DHMH 17 Rev 7/2009

State

1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Duran, MD
31. Date filed (Month, Day, Year)

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Feb. 25 2011 BURYON 2:00A M onva Medical 4a. Facility Name (in not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3336 Curtis Drive #102 Prince George's Hillcrest Heights If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Pay, Year)
Dec. 18, 1964 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🎛 F 578 88 7272 46 DC Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Hillcrest Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3336 Curtis Drive #102 USA 20746 IJsa Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Š 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 SpecifyBlack 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) Teacher DC Government 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fil of Health and Mental fitem 27 is marked ပ Arthur Burton Linda Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 Charmice Burton/Daughter 3336 Curtis Dr.#102 Hillcrest Hats..MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite Page 1 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem.Cem. 3/7/2011 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBriscoe-Tonic Fueral Home 2294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical nding plans tase t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No for Month Year Day Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð To the Hospital or Attending Physician: The law requires t within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 2 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No 4 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated who completed cause of death (Item 23a) (Type, Print) X BZ Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February , 2º0 11 8:50P M Claude Brown Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Clinton Nursing & Rehab. Center Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min July 1, 1949 Wash., DC Director 577-64-9464 61 Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits with the Maryland 10c. City. Town or Location Director 1 XYes 2 No Charles Waldorf MD 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 20602 12139 Dornock Court United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Black er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. 12 Telemarketing Private marked other Be منا be file معلله and Mental Hy: **If item 27 is mark**ه الا **r other tr** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Claude Brown Sr Bertha Mae Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12139 Dornock Court
Waldorf, MD 20602 Page 1 and 2 s' ment of Health a Shirlene Ogburn/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage Mem. Cemetery Waldorf, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 Part 1. Inter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Brain Tumor Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hypertension or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hepatitis C Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown hed 9 Unknown P. 0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and phase, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) D0025640 anac in pleted cause of death (Item 23a) (Type, Print) 7801 old Branch Ave., #409, Clinton, 40 20735 M.D. 31. Date filed (Month, Day,) State Registrar

11-01415 Devin Boston Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 19, 2011 1619 hrs Medical Examiner BOSTON 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b City Town, or Location of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or Foreign WASHINGTON 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Director Country) 578-92-8156 1 XM 2 F 46 MAY 21 1964 DC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 X Yes 2 No 28a-f show PRINCE GEORGE'S Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. HYATTSVILLE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10<u>00 BRIGHTSEAT ROAD</u> 11 Marital Status 14 Race - American Indian Black 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year BLACK 1 Yes 2 No specify. ≦ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DRIVER GOVERNMENT 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be EARL SPEARS YVONNE19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YVONNE D. ROGERS/MOTHER 1000 BRIGHTSEAT ROAD #112 HYATTSVILLE, MARYLAND, 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify HARMONY CEMETERY /1/2011 LANDOVER MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service License J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Day Year past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ Other Nursing Home 5 Residence 6 Other: this 1 V Yes 27. Manner of Death 28a Date of Injury 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: Feb 19, 2011 Driver auto auto collision Natural 1510 hrs 1 Yes 2 ✓ No Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) I-95 & Route 4, Upper Marlboro, MD within 24 hours a determined (Specify) Interstate/Express Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 20, 2011 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Yea 32. Registrar's Signatu State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death

3. Time of

			State Registrar		C	ertific	cate of D	eath			Reg. No.			
	 		1. Decedent's Name (First, Middle, Las	st)				2. Date of De		Year	3. Time of Death			
	Physicia Medic		Blair	John	Cr	abtr	ee, Sr	•		Februa	ry 23.	2011	5:55 P M	
	Examin		4a. Facility Name (if not institution, give 15700 Packard D			4b.	City, Town, or	Location of Lumber	Death	d	4c. Count	y of Death A1	legany	
	Funeral Director		210-30-0003		yrs. last birthda 70 Yrs	Mor	Inder 1 Year oths Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 09/27		9. Birth Cou Mar	nplace (State or Foreign ntry) 'Y Land	
	D w	_	Usual Residence of Decedent 10a. State 10b. County	140	c. City, Town or	Location							10d. Inside City Limits	
	ırylan ı-f sh ied a	cto	MD Alleg		o. City, Town or		mberla	nd					1 🗆 Yes 2 🛣 No	
	ne Ma notif	Dire	10e. Street and Number	,arry			f. Zip Code				10a, Citizen of	What Cou		
	h with th	Funeral Director	15700 Packard					2 1 502				JSA		
	r iten iner r		11. Marital Status	12. Was Decedent Ever Armed Forces?			ecedent of His specify Cubar			cify Yes or No- Rican, etc.)		ce - Ameri ck, White,	ican Indian, , etc.	
9200	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.	1962		es 2 🕅 No				Specif	y:	White	
2	72 ho n "nat edica	Completed	15. Decedent's E (Specify only highest gr		(G	ive kind o	Usual Occupa f work done d		of worki	ng	16b. Kind of I	Business Ir	ndustry	
2	ithin ene. thar the M	[등	Elementary/Seconday (0-12)	College (1-4 or 5+)	IITE		Tuse retired) Iductor				Ra	ilroa	ad	
2	led w Hygi othel	Be	17. Father's Name (First, Middle, Last)				I	18. Mothe	r's Name	e (First, Middle,	Maiden Surnan			
<u>lan</u>	l be fi fental rked fic ev	입	Dennis	John (Crabtree	;		Hel	Dev	ena S	pidel	L		
Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once.		19a. Informant's Name/Relationship (1 Janice M. Crabtro	,, ,	19b. M	lailing Add	dress (Street a Packar	nd Number d Dri	r or Rura .ve,	Route Number Cumber	er, City or Town, land, M	State, Zip D 2	Code) 1502	
ore,	of Heg		20a. Method of Disposition		20b. Place of Di		(Name of or other place	e)	[Date	20c. Location	- City or T	Town, State	
Ĕ	Page ment ant: I		1 🎇 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the Con		Restlav	ın Me	m. Gar	dens			LaVa	,		
Baltimore,	permit. Depart Import any inj once.		21. Signature of Funeral Service Ocen	See O						ams Fan , Cumbe	Home, P.A. 21502			
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the	e death. Do not	enter the	mode of dying	g, such as c	cardiac c	r respiratory a				
þ	hysician/		Immediate Cause (Final disease or condition	79712	STAN	C	INNO	G C	AN	COR			Onset and Death	
لمحيد	Medical Examiner		resulting in death)	Due to (or as a co			V						7.0	
		<u>-</u>	Sequentially list conditions,	t								20.0		
	ed .	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co	onsequence or):									
	certificate be executed inding physician and use as the burial-transi		that initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):									
9	s be e /sicial e burl:	/Medical		d										
98760	ificate ng phy as the	Med	IF FEMALE:											
٠ ×	h cert tendir r use		23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcome of p	Fetal death	3 🗌 Ecto	opic pregnanc	y				ate of deli		
P.O. Box	he deat y the at iched fo	Physician	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown	ne of death	5 Oth	er (specify)					onth	Day Year	
P. 6	law requires that the death certificate be executed nas been signed by the attending physician and 2 should be detached for use as the burial-transit	à	Part II. Other significant conditions of	ontributing to death but r	not resulting in ti	ne underly	ing cause giv	en in Part I.					the cause of death?	
g	requir been s should	etec								24a. Was			opsy findings available	
ecc	sician: The law is certificate has be lirector, page 2 s	Completed								auto perfe	psy ormed?	prior to codeath?	ompletion of cause of	
<u> </u>	an: The tifficat tor, pa	Be C	25. Was case referred to medical				26. Pla	ace of Deat	h (Check		2 No	1 🗆 Yes	2 L NO	
X :	nysici lis cer direc	To E	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpa	atient 3	DOA Othe	r; 4 🗆 Nu	rsing Ho	me 5 🗓 Resi	dence 6 🗆 Ot	ner (Specit	(y)	
o '	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Ye	28b. Tim ear) inju		28c. Injury work	?	- 1	28d. Describe	how injury occur	red		
0	tendi Jeath. tor: A the fu	Certificate:	2 Accident Investigatio			М		Yes 2 🗆	-					
Division of Vital Records,	cal or Al		4 Homicide determined	28e. Place of Injury - building, etc. (S		street, ta	ctory, office			28f. Location (City or To		ber or Hura	al Route Number,	
_ ;	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certific completed filled in by the funeral director,	Medical		nination and/or in	vestigatio	n, in my opinio	n, death oc	curred at	the time, date	and place, and d	ue to the ca	ause(s) and manner stated.		
;	To the within To the сопры	Σ	only one) 3 \(\subseteq\) Certifying Nur 29b. Signature and title of certifier	st of my knowledge, death occurred at the time, date and place, and d 29c. License number						29d. Date sign				
	5+		> / /	D50844 February 24, 2011										
			30. Name and address of person who											
ú	MAS		Jose T. Loveri	//										
	Stat		31. Date filed (Month, Day, Year)	32/Registrar's	Signature	bank							:	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ellis M. Chaney Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Western MD Regional Medical Center Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min 1 XM 2 - F Months (Month Day, Your) 1917 Maryland 217-07-5727 93 Director Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 191 Ormand Street 10f. Zip Code 10g. Citizen of What Country? ò 23a U.S.A. 21532-"natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 Widowed 4 Divorced WWI the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) auto repair mechanic traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Linnie Viola Layman Charles Darrell Chaney permit. Page 1 and 2 should be Department of Heatth and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland Viola Chaney 191 Ormand Street Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Mount Zion Methodist Cemetery 1 K Burial 2 Cremation 3 Removal from State Frostburg Maryland February 21, 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Exami that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Month signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 \square Pending 1 Yes 2 No Investigation Accident Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year) FEB 22 2011

En Keshofi

30. Name and address of person who completed cause of Yeath (Item 23a) (Type, Print)

12500

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

000 68455

millow brook road, Cumberland, MD

2,21,11

that the death certificate be Box 68760 Hospital or Attending Physician: The law requires Records, Division of Vital To the Hospital or Attendir within 24 hours after death.

To the Funeral Director, At completed filled in by the fu

Baltimore, Maryland 21215-0036

/ WA MRS

Medical

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

only one)

3

vino

29b. Signaty¶e and title of certifier

30. Name and address of person who completed cause of death (Item 23a (Type, Print) Robustiano J. Barrera, Jr., M.D., 200 Glenn Street, Ste 302, Cumberland, MD 21502 2. Registrar's Signature

saine

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

-14865

29d. Date signed (Month, Day, Year)

FEB

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month FEbruary Louis George Cossette 20 Î Î 2:40 а м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 CT 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday April 3, Year) 914 Hours Min 1 M 2 - F 96 Director 577-01-5789 Usual Residence of Decedent 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MDMontgomery Kensington 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 10611 St. Paul Street 20895 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, vas Decedent Ever in L Armed Forces? 1. Yes 2 No If Yes, Give Year or Dates. WWII Black, White, etc. ò 1 Never Married 2 Married Ş Maryland 21215-0036 White should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Postal Worker Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Marie Utrecht Louis George Cossette permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Gerard Cossette/Son 14406 Gaines Avenue, Rockville, MD 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/1/11 Gate of Heaven Cemetery Silver Spring, MD 4 Donation Other (Specify) Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funyral Ser 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No detached for Day Year Pregnant at time of death the g 🔲 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ The law requires Completed 2^N No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? Yes 2 No certificate To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Vital 25. Was case referred to medical e B 26. Place of Death (Check only one) examiner? 2 🖾 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 - Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D67986 Feb. 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuneng Li, MD 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar FEB 38

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	ו	AMEND # 25,27,				Cer	rtificate c	of Dea	ath			Reg. No.	Ordinary - Com-	2 8	
Physic:		1. Decedent's Name (First, Middle								1	2. Date of De Month	Day		Year	3. Time of Death
Physician Medica	al _	OZELLIA CR			1					2000	02-1.5	1-201	1.1		D704 A ^
Examine		4a. Facility Name (if not institution				05	4b. City, Tow					4c.	County Prin		George's
-HDOW-II	F	Prince George 5. Social Security Number	6. Sex	7. A	<u>l Cent</u> Age (In yrs. Ia:	st birthdav)	If Under 1 Y	Year If U	f Under 24	4 Hrs.	8. Date of Bit	rth		9. Birt	thplace (State or Foreig
Funeral Director	ľ	577-30-3143	1 M 2		Age (III y is. ia.	Yrs.			Hours	Min.	(Month, Da	_{ay, Year)} 4-1-9-	22	Co	untry) VA
*		Usual Residence of Decedent				(Town	cation								10d. Inside City Limit
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or 28a notifi	e	10e. Street and Number					10f. Zip Co					10a Ci	itizen of V	What Co	- 111
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ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Funeral Director	2125 10th St	12. W	as Deceden	nt Ever in U.S	3. 13. \	Was Decedent If Yes, specify			1? (Spec	cify Yes or No	-	14. Race	ce - Ame	erican Indian,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 24 Earle Wesley Coleman February 2011 11:32 Medical ^{4a.} Facility Name (if not institution, give street and number) Star Care Partner Assisted Living 7211 Leona Street **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>District Heights</u> Prince George's 7. Age (In yrs. last birthday) 90 yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Wash 1 XM 2 🗆 F Months Hours Min 08/15/1920 Director <u>578-1</u>2-7265 .D.C Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits at 10c, City, Town or Location Director Examiner must be notified 1 🔀 Yes 2 🗆 No D.C. Washington 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral with 4719 Eads St., N.E. 20019 U.S.A. items ; death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. 72 hours after "natural", or 21215-0036 Black 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dept. of Agriculture Elementary/Seconday (0-12) 12th College (1-4 or 5+) Economic Specialist U. S. Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Paul Earl Coleman Nannie Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Stewart/Niece 6306 Fur Seal Court, Waldorf, Maryland 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Olivet Cem. 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. 03/05/11 Washington,D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. an naul 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) -10 min Respiratory Arrest Medical Due to (or as a consequence of): Examiner Sensis 48 hours Sequentially list conditions. Examine if any, leading to immediate
the Enter Undergray
Cause (Disease or linjury Due to (or as a consequence of): that the death certificate be executed the burial-transi Left Hip Abscess 4-5 days and that initiated events resulting in death) Last Due to (or as a consequence of physician Physician/Medical 4-5 weeks Left Hip Decubitus Box 68760 attending use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 4 Pregnant g Unknown 5 Other (specify) Month Day Year Pregnant at time of death I signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Division of Vital Records, Malnutrition 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Adult Failure to Thrive 24a, Was an has autopsy performed? Yes 2 No certificate | Vascular Dementia 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 😿 Other (Sp. 1 ☐ Yes 2 🔀 No Hospital: Assisted Living 2 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🗷 Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Serlemitsos, M.D.

31. Date filed (Month, Day, Year)
NAR 0 2 2011

D0032654

2033 Penderbrooke Drive, Crownsville, Maryland

February 26,2011

Ame	nded #19a FD, Alle	, n gan	ls, 03/01/1 v Co.	1, Plea							s Are Legible	
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			Registrar 1. Decedent's Nam	e (First, Middle	e, Last)			tincate of t	Jean	2. Date of De	Reg. No. ath	3. Time of Death
	Physicia Medic		IRIS 1	EILEEN	DAWSON					Manth	Pay Year	0945 M
•	Examin	er			n, give street and num		Center	4b. City, Town, o	r Location of Death rland		4c. County of De	
	Funeral Director		5. Social Security N 215-20-	-6641	6. Sex 1 \(\text{M} \) 2 \(\frac{1}{X} \) F	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 12/11/	th 9. E 1926 M	Birthplace (State or Foreign Country) ARYLAND
	nd show at	. I	Usual Residence of 10a. State	Decedent 10b. County		10c. C	City, Town or Lo	cation		· -		10d. Inside City Limits
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	ith the 23a or 3	Funeral Director	10e. Street and Nur		IN DRIVE			10f. Zip Code 1552:	2		10g. Citizen of What U.S.A	
	eath w	Fune	11. Marital Status	21(111/1	12. Was Dece	dent Ever in U	J.S. 13.		dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ar	nerican Indian,
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	2	1 Never Man	4 Divorced	If Yes, Giv Year or Da	_2 X №		1 ☐ Yes 2 🏹 No	Specify:	Tucan, etc.)	Black, Wh	· ·
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Maryland	should be filed within 75 and Mental Hygiene, is marked other than 's umatic event, the Me	To Be	17. Father's Name (Last) NUNEBREN	NER				ne (First, Middle, OLIVE (Maiden Surname) GRADY	
	nd 2 shou ealth and n 27 is m		19a. Informant's N	ame/Relations	hip (Type, Print) IS / DAUGH	TER		-	and Number or Rur EN DRIVE,		er, City or Town, State, D, PA 155	
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Dis 1 Durial 2 4 Donation	Cremation	3 Removal from	State	cemetery, crei	osition (Name of matory or other place ND CREMAT	ce)	Date 9/2011	20c. Location - City	or Town, State
altir	rmit. P spartme iportar iy injur		21. Signature of Fu			/			OILL	CHURCH F	UNERAL HOM	
<u> </u>	9 9 E 6 9		YRON	Q 91	compliations that						ERLAND, MD	21502
-	Physician/		shock, or hea Immediate Cause disease or condition	rt failure. List ((Final	only one cause on ea	ch line.	ley2	ratory	Paller	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)		Due to	or as a conse	1 1/	reum	La			2 weeks
	ed	Examiner	Sequentially list contains any, reading to in cause. Enter Under Cause (Disease or	nmediate rlying	D. Due to	or as a conse	quence oi).					
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Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		Birth 2 🗌 Fe nant at time o	etal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of Month	delivery Day Year
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f Vit	Physic this ce al dire	욘		No	Hospital: 128a. Date		ER/Outpatie		4 ☐ Nursing H		dence 6 Other (Sp	ecify)
o uo	ending l sath. or: After he funer	ficate	1 Natural 2 Accident	5 Pendi	ng (Mon igation	th, Day, Year)	injury	worl		28d. Describe r	now injury occurred	
Division of Vital	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical Certificate:	3 Suicide 4 Homicide	6 🗌 Could detern	28e. Place	of Injury - At I ng, etc. (Spec	home, farm, str ify)	eet, factory, office		28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
	n 24 hour n 24 hour ne Funera	Medica	(Check 2	Medical I	Examiner: On the bas	is of examinat	ion and/or inves	tigation, in my opini	on, death occurred a	at the time, date a	ause(s) and manner as and place, and due to the ne cause(s) and manner	ne cause(s) and manner stated.
			29b. Signature and	title of dervifie	for			29c. Licens	e number 0 3 3 2 8 4)	29d. Date signed (Mo	nth, Day, Year)
	nLs		30. Name and addr	ress of person	who completed caus	se of death (Ite	em 23a) (Type, 1	Print) Ave,	Ceenha	ulano	29d. Date signed (Mo Feb 17	502
	Stat Registra		31. Date filed (Mor	Ba2/3	2011 Pen	egistrar's Sigr	dure face	Ked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ WAYNE D. DOWNS 2011 2:00 a FEB Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death DISTRICT HEIGHTS Examiner PRINCE GEORGE 1800 ADDISON ROAD SOUTH 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 578--90--9681 1 ▼ M 2 □ F 37 WASHINGTON DC Director Yrs Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10h County 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location Director MDDISTRICT HEIGHTS 1 Yes 2 □ No PRINCE GEORGE 10g. Citizen of What Country? ÜS 10e. Street and Numbe 10f. Zip Code Funeral 20747 SOUTH ADDISON ROAD 1800 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 😾 Never Married 2 🗆 Married 1 ☐ Yes 2 🛣 No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) DEPT. HUD ASSISTANCE MANAGEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, , Maiden Surname) E LAW should be file and Mental H is marked o ၀ INEZ CATHERINE DOWNS CURTIS JAMES 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 ADDISON ROAD SOUTH DISTRICT HEIGHTS MD 20747 INEZ DOWNS - MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oti 1 Burial 2 S Cremation 3 Removal from State RIVERDALE PK CREMATORY 3/8/2011 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE MARYLAND Signature of Funeral Service Licens 22. Name and Address of Facility POPE FUNERAL HOME 5538 MARLBORO PIKE FORESTVILLE MARYLAND 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease. Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Day Year Yes 2 🗆 No the 9 Unknown 9 Unknown signed by t Other significant conditions contributing to death but no resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 🗌 No Yes 2 N 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No injury 5 Pending Accident
Suicide after death Director: Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 🗌 only one) 00055314 SYLVESTER OKONKWO 6192 OXON HIL Rd, STE 507 DXON HIL, MD 20745

State Registrar MAR 0 2 2011

32. Registrar's Signature

Amende oer FD	d #20b	, n	1s, 02/23/ y Co.	¹¹ Please T	ype or Print in	Black	Indelil	ole Ink	. Ensure	All Copie	es Ar	e Legible	
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and the same of th			WMHS 6	REGIONA ber 16. Sex		L CT	4	er 1 Year	If Under 24 Hrs.	8. Date of B	irth	Allega	rthplace (State or Foreign
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(0	or item	by Fur	11. Marital Status 1 Never Married		2. Was Decedent Ever in Armed Forces? 1 Yes 2 No	U.S. 1:			spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Whi	
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	욘	_	THEODO	RE SHRO	OYER	2		ALVER				MERICK
Mar	2 shoul Ith and 27 is m traum		19a. Informant's Name		, Print) NERTCK	1	ailing Addre		nd Number or Rui	_			ip Code) IN PA 15545
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Baltimore,	nit. Pag artment ortant: injury o	1		Other (Specify)		2-19	22. Name :		Sery Z-/G s of Facility	1-7011		NDMAN	
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P.O.	that the led by the detach				ributing to death but not	resulting in th	ie underlyini	g cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
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Division of Vital Records,	g Physi er this c neral dir	te: To	1 Yes 2 27. Manner of Death	NO	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time	e of	28c. Injury work	4 L Nursing H ≀at	28d. Describe		6 Other (Speury occurred	ecify)
ion	ttendin death. stor: Afi / the fur	Certificate:	2 Accident 3 Suicide	5 ☐ Pending Investigation 6 ☐ Could not be	28e. Place of Injury - At		M	1 🗆	Yes 2 No	28f Location	Street	and Number or R	ural Route Number,
Divis	tal or A rrs after al Direc led in by		4 Homicide	determined	building, etc. (Spe				9	City or To			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 [Medical Examine	ian: To the best of my knors: On the basis of examinal Practioner: To the best of	ation and/or in	vestigation, i	n my opinic	on, death occurred	at the time, date	and pla	ce, and due to the	e cause(s) and manner stated
	To the	2	29b. Signature and title	e of certifier	,			9c. License	number		29d. [Date signed (Mon	nth, Day, Year)
	5		30. Name and address	of person who con	noteted cause of death (It	00 \ (T	e, Print)		4987			-18-201	
	nes		(hRISTOD	her S. T	JAGNON, M	D	925	Sez	ton DRI	ve Ci	embr	erland	Md. 21502
	Sta Registr		31. Date filed (Month)	3 2011	32. Registrar's Sig	arure av	Led.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ vielv in 1034 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center umberland egans If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 02/07/1937 West Virginia 235-54-7972 74 Director Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location Director Greenspring 1 Yes 2 No Mineral 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26772 USA HC 86 Box 54C Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2 💢 No Black, White, etc. ò ò 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Truck Driver 12 Be 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Kay 17. Father's Name (First, Middle, Last) Davis 2 Gillaspie Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Douglas Street, Joliet, IL 60435 Brian Gillaspie / Son Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Cumberland Crematory 03/01/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Rome, of Funeral Sprvige Licenses 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? has page 2 this certificate 1 ☐ Yes 2 ☐ No Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 21 ျှ 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at work? 1 🗌 Yes Certificate: 28d. Describe how injury occurred After iniurv 1 Natural 5 Pending 2 🗆 No Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Hospital Medical 🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only on 29b. Sign

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

MAR 01

32. Registrar's Signature

Amended per FD	d #19b,	, nl jany	s, 02/22/11 Co.	• Plea			nt in Black								ole.	
			For State Registrar		State	OI IV	aryland / De C	parime e <i>rtifica</i>			and ivie	ептаг пу	_	ZUI	1	08176
			Decedent's Name	e (First, Middle	e, Last)			5, 1,,,,,,		-		2. Date of De				3. Time of Death
	Physicia Medio		Betty T. G	arlitz								O D Month	ام الم	20	rear	14:40 PM
	Examin	er	4a. Facility Name (if Western M)		, give street and no al Medical C			4b. Cit	y, Town, o	r Location o Cumbe				. County of Llegany		
	Funeral Director		5. Social Security Nu 215-20-602		6. Sex 1 □ M 2 🛣 F	7. Ag	e (In yrs. last birthda) 85 Yrs.	/) If Unc	er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da June	rth ay, Year)	925	9. Birthp Coun Mary	place (State or Foreign tty)
		١. ا	Usual Residence of	Decedent					-							
aryland	a-f she fied af	cto	10a. State Maryland	10b. County	gany		10c. City, Town or Frostburg	Location								0d. Inside City Limits 1 ¥ Yes 2 □ No
vith the Ma	23a or 28 st be noti	Funeral Director	10e. Street and Num		Mount Pleasa	ant Str			ip Code		-		10g. Cit	tizen of Wh	at Cour	
21215-0036 within 72 hours after death v	nt of Health and Mental Hygiene. It if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Me Ical Examiner must be notified at	ক্র	11. Marital Status 1 Never Marri 3 Widowed	•	15 Va - C	Forces? s 2 K Sive		3. Was Dec If Yes, sp	edent of H	lispanic Orig an, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- ican, etc.)		14. Race - Black,	Americ White, o	etc.
5-0	"natu e iical	Completed	(Spec		nt's Education est grade complete	ed)	(Gir		ork done	during most	of working	,	16b. K	ind of Busi	iness Ind	dustry
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Maryland 2	fental Hyg rked othe tic event,	To Be	17. Father's Name (F Weaver Tu		ast)					1	er's Name (First, Middle,	, Maiden	Surname)	•	
, Mary	ealth and N m 27 is ma ier trauma		19a. Informant's Na Linda Garl		hip (Type, Print) Daug	hter	195 M 153 M 10437	iling Addre OUNT P BUILUIT	ss (Street Jeasar Park D	and Number it Stre	r or Rural P et, Fr Flost	Poute Number ostburg	er, City or	79%25ta 21532ta 21371a	te, Zip C	Code) 21532-
Baltimore,	E E C		20a. Method of Disp 1 A Burial 2 Donation	☐ Cremation	3 ☐ Removal fro	m State	20b. Place of Dis cemetery, c Mount	ematory of	other plac		Da February	nte 19, 2011	l	ocation - C stburg		own, State Iaryland
Balti permit.	Depart Import any inj once.		21. Signature of Fun	neral Service L	icensee	ını	7			ss of Facility al Horne		ost Ave.	, Frost	burg, N	/ID 2	1532
. Phy	ysicianz	1 2 (6)	23a. Part 1. Enter the shock, or hear Immediate Cause (F disease or condition	t failure. List o Final	complications that	t caused each line					93	respiratory a			9	Approximate Interval Between Onset and Death
() N	Medical taminer	П	resulting in death)		a. Due t	o (or as	a consequence of):	LUCI	IV;	2010		1) [2]	13			
B	it	Examiner	Sequentially list confirming to improve cause. Enter Under	nditions, mediate lying	b. Due t	o (or as :	з сы ведиенсе Л;									
executed	an and irial-trans	I – I	Cause (Disease or i that initiated events resulting in death) L	injury	c. Due to	o (or as	a consequence of):								+	
7 60	physici the bu	edica			d											
P.O. Box 68760 that the death certificate b	winn! 4.4 nours ander deam. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent p in the past 12 n 1 Yes 2 4 9 Unknown	nonths?	1 ☐ Liv	e Birth egnant a	of pregnancy 2	Ectopi		ру				23d. Date Monti		ery Day Year
IS, P.O	n signed by	ρ	Part II. Other signifi							ven in Part I.						ne cause of death?
Division of Vital Records, alor Attending Physician: The law requires	ate has been sign page 2 should be	Completed	Ci	PRONF	try Ar	216	ART FAI	EASIZ				24a. Was auto perfe 1 \(\subseteq \text{Yes}	psy ormed?	pri de:	or to co ath?	osy findings available mpletion of cause of
tal F	ertifica ctor, p		25. Was case referre examiner?	d to medical	Tiloscoposon		- 1944 - 194W-1	0019 20	- 4	ace of Deat	h <i>(Check</i> o	•	2 140		163	2 110
of Vid	this cral dire	유	1 Yes 2 2 27. Manner of Death	No No		Inpation	ent 2 ER/Outpat		DOA Oth	4 ∐ Nu		e 5 Resi			(Specify)
ion o	earn. or: After the fune	Certificate:	1 N Natural 2 Accident 3 Suicide	5 Pendin Investig 6 Could	ng (Mo gation	onth, Day			work		- 1	ld. Describe I	now injur	y occurred		
Divisi alor Att	s arrer o		4 ☐ Homicide	determ	ingal 28e. Plac	ce of Inju Iding, etc	ry - At home, farm, : :. (Specify)	street, facto	ry, office		28	3f. Location (City or Tov			or Rural	Route Number,
Le Hospit	within 24 nouts arter death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2	Medical E	xaminer: On the b	asis of e	my knowledge, deat xamination and/or inv best of my knowledg	estigation, i	n my opinio	on, death oc	curred at th	ne time, date a	and place	, and due to	o the cau	use(s) and manner stated.
10 m	P To the		29b. Signature and t	itle of certifier	Hudh	^			J) Z(number				te signed (I Runf		Day, Year) 7. 20((
P	2RA		30. Name and addre					, Print)			nber	land		2150	*	
	Stat	e	31. Date filed (Month	n, Day, Year)	11 4 32.	Registra	shop Wa		wau	Guil	HUCL.	Land	עוי	<u> </u>	<u>, , , , , , , , , , , , , , , , , , , </u>	
	Registra	ar	reb	11 40	Lance		/ //									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar AMEND#9per INF, 3/3/11: BMW, MbCb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Delores Elizabeth 2011 2:58 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 579-36-4657 8. Date of Birth
SEPT 12, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 XXX Hours **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 X No Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 4 David Court 20904 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Augusta Davis Phoebe Dietzler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8145 Poinsett Terrace, Pasadena, MD 21122 Linda Mebane/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 3 Removal from cemetery, crematory or other place) 1 X Burial 2 / Cremation State 3/2/2011 Other (\$pecify) Adelphi, Maryland George Washington Cemetery Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 . Signature of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 4. Enter the disease, shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ a Acute Respiratory Failure Medical Due to (or as a consequence of): Examiner Hypercarbia Sequentially list conditions, if any leading to immediate Examiner Due to (or as a consequence of) if any, leading to immedicause. Enter Underlying COPD To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriar-transit Sait Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes 2**X** No Other: မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number **D** 6 5 3 0 5 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Feb. 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nabila Khan, Md 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State PEB 28 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 8:40p M Gwathney Mary Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles Waldorf 327 Garner Ave 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Funeral 1 □ M 2**X** F Months Days Hours Min. 3-5-1909 Queens NY Director 089-20-4671 101 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at Director 1 X Yes 2 No Brandywine MarvlandPrince George 10g. Citizen of What Country? 10f. Zip Code 6 10e. Street and Number items 23a Funeral USA 14320 Brandywine Rd 20613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black "natural" Completed 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. P.G. Bd OF Elementary/Seconday (0-12) College (1-4 or 5+) the Education Bus Aide other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other transmit filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lambert Ε. Lee Mary Wayman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14320 Brandywine Rd, Brandywine MD 20613 Marilyn Marlowe/Grand-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/2/11 Alexandria Va Metropolitan 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 410 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last certificate be executed Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year been signed by the atte should be detached for Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown 1 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 M Other (Specify) examiner? Hospital: 2 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA hivin 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Wedical Examiner. On the basis of oxidim later and place and place, and due to the cause(s) and manner as stated.

 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

285

State Registrar Michael Leatherwood 1
Date filed (Month, Day, Year)

32. Régistrar's Signature

MAR 0

12070 Old Line Cntr

Suite 302

20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2, 2011 Gladys Marie Guthrie 8:50 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Garrett Goodwill Mennonite Home Grantsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept • 30, Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 💢 F Days Min. Months Hours Maryland Director 88 1922 218-30-0642 Usual Residence of Decedent shov 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location Director 28a-f 1 Yes 2 X No MD Grantsville Garrett 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 1568 Durst Rd. 21536 USA death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 9 1 Never Married 2 Married filed within 72 hours after by Yes ? 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Jeremiah Durst Anna Broadwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda S. Miller/Daughter 1582 Durst Rd., Grantsville, MD altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Grantsville Cemetery March 5, 2011 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Services 22. Name and Address of Facility Newman Funeral Homes, P.A. icenses P.O. Box 275, Grantsville, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Immediate Cause (Final Physician/ 1 WEE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a cons quence of) burial-transi Due to (or as a consequence of): ŵ resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? ò Month Day Year Pregnant at time of death the detached 9 Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to dealin but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an Were autopsy findings available prior to completion of cause of autopsy autops, performed Vac 2 certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ပ 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Deat 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending work' 1 🔲 Yes 2 🗌 No Investigation 6 Could not be filled in by the 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical

State Registrar

completed

the

29a. Certifier

only one)

29b. Signature and title of certifier

2 mona 31. Date filed (Month, Day, Year)

- 4 2011

Com 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 455 Physician/ leanor Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Forestville Prince George 7816 Marlboro Pike 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral Min 6-13-19 Hours Washington DC 76 Director 212-34-9502 Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director tx Yes 2 ☐ No Maryland Prince George Forestville 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 20747 USA 7816 Marlboro Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Force Black, White, etc. 5 þ 1 Never Married 2 Married 2√ No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Black Completed of Health and Mental Hygiene.
If item 27 is marked other than "natur rother traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Proctor Lessie Proctor Alvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Red Brick Rd, Garner 1013 NCJoseph H<u>arley Jr./ Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 **X**Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ÷ 5 Department of Important: If any injury or once. Resurrection 3/8/11 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility relesa Home Pa, Aquasco MD 20608 Adams Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ne disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ng physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year ģ 5 Other (specify) Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should l 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be DAUGATER Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 4 Nursing Home 5 Residence ည Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 8c. Injury at Natural Accident 5 Pending work?
1 Yes 2 No Investigation Could not be Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 🗌 Suicide 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

AG3 State

31. Date filed (Month, Day, Year)

32. Redistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Prij

d. Sark

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February Рм 2011 Dorothy M. Butler Horton 7:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Hyattsville Prince George's 8. Date of Birth (Month, Day, Jan 4 Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Min. Days Hours Country Director 82 Jan Alabama 228-30-4787 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 X Yes 2 No Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6303 Joslyn Place 20785 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Nurse DC Government any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Harris Mary Calloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Jerome Butler /Son Bay Highland Dr. Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery! 3/5/2011 Brentwood, Md . Signature of Funeral Servi 22. Name and Address of Facility Fort Lincoln Funeral Home censee 1anco 3401 Bladensburg Rd Brentwood, MD 20722 23a. art 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart fail (re./ ist only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a va consequence of Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine ohysician and the burial-transit The law requires that the death certificate be executed attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death buy not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Nnknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes 2 No Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pl 24 hours after death. Funeral Director; After the Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 29c. License number 29d. Date signed (Month. Day, Year) 2011 34 22, ddress of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day Year) Teras

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle	, Last)			infourt		- Cutii		2. Date of Dea	Reg. No. 2	J 	3. Time of Death A
	Physicia Medic		Deborah Lee Imes								Month	7ªx	Year	0803 1
	Examin		4a. Facility Name (if not institution	, give street and nu	mber)		4b. City,	Town, or	Location o	of Death		4c. Coun	y of Death	
			Western MD Region	nal Medical C	enter				Cumb	erland		Alleg	any	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da		9. Birthp Coun	olace (State or Foreign try)
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	or 28	<u> </u>	10e Street and Number	8 Buckeye L			10f. Zip	Code				10g. Citizen of	What Cour	ntry?
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Jano	d be f fenta irked tic ev	욘	William T. Imes						Delo	res Ca	rder			
a S	should and N is ma		19a. Informant's Name/Relationsl	nip (Type, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe	r, City or Town,	State, Zip (Code)
Σ	nd 2 saalth n 27 er tra		Delores Imes	mothe	er	P.O. Bo	x 510			Moı	ınt Savage	Mar	yland	21545-
e O	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from		Place of Dispos	sition <i>(Nan</i> natory or o	e of her place	e)		Date	20c. Location	- City or To	own, State
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00 3	endin use	an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregn Birth 2 - Fet		Ectopic p	reanancy	,			23d. D	ate of deliv	ery
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> 5 °	Phys this ral dii	<u>유</u>	1 Yes 2 No	28a. Date	Inpatient 2	EB/Outpatien 28b. Time of		Bc. Injury	4 ⊔ Nu		me 5 🗌 Resid 28d. Describe h			·)
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₹ .	al or a afte		4 - Homicide determ	build	ing, etc. (Specil	fy)					City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		Physician: To the										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:50 PM February 2011 David Cardiff Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Grantsville Garrett Goodwill Mennonite Home 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🕱 M 2 🗌 F Feb. 17 Year 1920 Onio Director 210-09-0662 91 Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Grantsville Garrett 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 21536 USA 147 Grant St. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>გ</u> 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Owner & Operator Coal Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Jones Melanie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health P.O. Box 354, Grantsville, MD 21536 William C. Jones, Sr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Country Side Crematory March 3, 2011 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 0 P.O. Box 275, Grantsville, MD Part 1. Enter shock, or he the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest art failure. List only one cause on ach line. Approximate Interval Between Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) ue to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dus to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Exa Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

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1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 17 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Certifical 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Mcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Bissell, 124 Miller St., Grantsville, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR - 4 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State Registrar	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	State of	Maryland		artment			and M		giene Reg. No.	01	**************************************	08184	
			1. Decedent's Name	(First, Middle, L	ast)		007	moure				2. Date of De	ath			3. Time of Death	٦
	Physicia	_	Edna	Jones								Month Febru	Day 1arv		ear 201	1 11:05 ^M A	
1	/Medic Examin	4	4a. Facility Name (If I		ive street and numb	er)		4b. City,	Town, or	Location o	of Death			County of			
		ally,	Larkin	Chase						wie	0411			rinc	e G	eorges	_
1 gam	Funeral		5. Social Security Nu		Sex 7. 1 M 2 M F	Age (In yrs. la		If Under Months	Days	If Under a	Min.	8. Date of Bir (Month, Da	ay, Year)		Count GA	ace (State or Foreign (ry)	
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	ter de Item	Funerai	11. Marital Status 1 ☐ Never Marrie	d 2□ Married	Armed Force	es?	. 13.	If Yes, spec	fy Cuba	in, Mexican	n, Puerto	ecify Yes or No Rican, etc.)			White, e		
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Вох	atten atten	clar	23b. Was decedent in the past 12 r 1 □ Yes 2 🖫	menths?	4□Pregna	th 2 □Fetat nt at time of de		□Ectopic pr □ Other (sp		/				Mont	th	Day Year	
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7,12	Regist	rar	MAK ()	I ZUII	(energy	P. A	- Charles										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ ARCAN Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince Georges Temple Hills 5713 Linda Ln. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1271771913 1 🗆 M 2 🗙 F W٧ 236-54-4282 97 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1X Yes 2 No Temple Hills MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number Funeral 20748 AZU 5713 Linda Ln. 2 should be filed within 72 hours after death v th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian rmed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be file of Health and Mental F item 27 is marked of ပ Mattie Price Alfred Lee Bedford White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5713 Linda Ln., Temple Hills, MD 20748 Beverly Jones Martin / daughter or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dunbar, WV 05/58/5017 Grandview Mem. Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Do 4500 Allentown Rd - Camp Springs. 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) meu mm Medical o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Box (Day in the past 12 months?
1 Yes 2 No Month ed by the 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 1 Tes 2 No 3 Probably 4 Inknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 1 Yes Yes iours after death.

eral Director: After this certifical filled in by the funeral director, I Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical To Be examiner? Hospital Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 2 29c. License number ompleted cause of death (Item 23a) (Type, Print) State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	in the past 12 r 1 Yes 2 9 Unknown	months?		nant at tir	☐ Fetal deat ne of death		Ectopic Other (s,t		у				Mon		Day	Year
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To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate hat completed filled in by the funeral director, page	edical			Physician: To the be													manner stated
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 08187 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PEARL ANNABELLE KIMBLE 2000 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Western MD Regional Medical Center Allegany Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 01/07/192 1 □ M 2 🔀 F Hours Min. Director MARYLAND 236-50-0579 Usual Residence of Decedent or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No FORT ASHBY WV MINERAL 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral ROUTE 46 - COUNTRY VILLA APTS. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian العا", or iter ا Examiner Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔯 No Specify Specify: WHITE "natural" 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER & HOUSEKEEPER MOTEL Ith and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ROBERT ELMER O'BRIEN ELLA MAE VALENTINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MADELINE FISHER / SISTER ROUTE 3, BOX 348, RIDGELEY, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUNSET MEMORIAL PARK 102/24/2011 CUMBERLAND, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ineumon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title Feb 21. 20/1 00033286 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, MD aunta Ave 625 Kent

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

68760

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patrick Keen, Jr. William рМ FEbruary 2011 7:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brooke Grove Nursing Home Sandy Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days NOV. 15, 1924 Months Min 1X M 2 □ F 86 PA 197-12-5670 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖵 No MD P.G. Hyattsville 10e. Street and Number 10g. Citizen of What Country? Funeral 2302 Woodberry 20782 Street USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1x Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify: Specify: White "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates. 1943-45 any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Systems Examiner Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Patrick Keen Mary Anna Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i William P. Keen, III/Son 5711 Osage Street, Berwyn Heights, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 ☑ Burial 2 ☐ Oremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) 3/4/11 Veteran's Cemetery Cheltenham, MD Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Sen ice Licensee 23a. Part . Enter the discase, or complications that caused the coath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ wonic Months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine transit that the death certificate be executed Due to (or as a consequence of): ng physician as the burial-Physician/Medical Bax 68760 attending for use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ rheumatoid arthritis; Records, polymya 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of rheumatica 24a. Was an autopsy death? this certificate Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this. | completed filled in by the funeral directors and the funeral directors are completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 12046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Grace Brookettuffman.

31. Date filed (Month, Day, Year,

M.D. 18100 Stade School Road Sondy

#28c Amended #26, nls, 02/23/11, per phy., Allegany Co. 1_state

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funcual		Western MD Region 5. Social Security Number	6. Sex	7. Age (In yrs.	lost hirthday)	If Under 1 Year			8. Date of Bi		III Gan			
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To the Hospital or Attending Physician: The law requires that the death c within 24 hours after death. Within 24 hours after death. To the Euneral Director: After this certificate has been signed by the attent completed filled in by the funeral director, page 2 should be detached for u	Medical Certificate: To Be Completed by Physician	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of University of Death 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin Investig 3 Suicide 6 Could 1 determined of Could 1 determined on the Could 1 d	d. 23c. If yes, out 1	Inpatient of injury - At hing, etc. (Specific the best of my know, is of each of the best of means and the bes	ancy al death 3 death 5 sulting in the unsulting in the u	26. Plot 3 DOA Other (specify) 28c. Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 29c. License 29c. License 29c. License 29c. License 29c. License	ven in Part I.	No 28 lace, and curred at that and place, a	24a. Was autoperful for the cale time, date and due to the	yes 2 [an psy primed No a	Montinese contribution of the contribution of	bute to the B Probere autopror to consath? (Specify) or Rural in as stated on the causer as stated and the causer as st	Day Year e cause of death? bably 4 Unknown by findings available impletion of cause of 2 No Route Number, d. se(s) and manner stated. bay, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Beverly Lipscomb Jeanne Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Allegany 4b. City, Town, or Location of Death **Examiner** WM Regional Medical Center Cumberland 7. Age (In yrs. last birthday) 72 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** ^{Year)}19<u>38</u> 234-60-4702 June 13 Months Hours 1 M 2 X F Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Garrett Bloomington Examiner must be notified MD 1 X Yes 2 No 10f. Zip Code 21523 ō 10e. Street and Number 10g. Citizen of What Country? 23a Funeral United States 40 Howard Ave. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2 Y No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 white 1 Yes 2 XNo Specify: 3 Divorced 4 Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. life. DO NOT use retired mentary/Seconday (0-12) College (1-4 or 5+) Housework Homemaker unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Warnick Eva McDowell Charles 19a. Informant's Name/Relationship (Type, Print)
Claude Lipscomb/ husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 40 Howard Ave, Bloomington, Maryland 21523 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Keyser, West Virginia 03/05/2011 Potomac Mem. Gardens 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home M 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and peath Immediate Cause (Final Ph_sician/ Pulmonary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a, Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) l e Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MD womachs 00055325 March 02, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland MD 2/502 925 Bishop WONSOCK SHIN 31. Date filed (Month, Day, Year) 32, Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 23, 2011 Fannie 9:30 a M Lyons Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Surburban Hospital Montgomery Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** March 22, Year)1915 1 M 2 X F Months Days Hours Min. Cumberland, Cty 579-12-1292 95 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director D.C. Washington 1 Kes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō "natural", or items 23a or Funeral with 2608 20020 33rd Street S.E. United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Completed 3 ₭ Widowed 4 ☐ Divorced Year or Dates er than "natura", the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ./nOfe,
oit. Page 1 and 2 sho.
"ent of Health and Me.
"item Z7 is marked o.
" traumatic ev. Rufus J. Maloy Kate McNeill 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 608 33rd. Street S.E. Washington, D.C. 20020 Karen Schmitz / Granddaughter 2608 Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 3/3/2011 Arlington National Arlington, Va. 4 Donation 5 Other (Specify) Signature of Funeral Service Lice Nempendades of Facility Pope PA 5538 Marlboro Pike/ Forestville, Md. 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pseudomonas UTI Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consection of of The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ρ 5 Other (specify) Month Year Pregnant at time of death g Unknown the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Severe Protein Calorie Malnutrition, Cerebrovascular 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Disease, Cardiovascular Disease, Chronic Obstructive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Pulmonary Disease, CHF 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ 1 Marient 2 ☐ ER/Outpatient 3 ☐ DGA 4 Nursing Home 5 Residence 6 Other (Specify) After this pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work' 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗆 Homicide determined To the Hospital Medical Ecritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53367 February 23, 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shyamsundar Rajan, MD. 9801 Georgia Ave. Suite 117 Silver Spring, Md. 30. Name and address of person 20912

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day Year NAR 0 2 2011

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MOSES 0718 LIFSEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPUTA MONTGOMERI GEN ONT60MELY OTHEM 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. Months Davs Hours Country) VIRGINIA 1 XM 2 D F Director 228-38-6735 76 1934 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3436 CHISWICK COURT 20906 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other treasment. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: BLACK If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRODUCE CLERE PRIVATE Be 18. Mother's Name (First, Middle, Maiden Surname)
CARRIE WILLIAMS Father's Name (First, Middle, Last)
PERCY LIFSEY ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3436 CHISWICK COURT SILVER SPRING, MARYLAND 20906 SHIRLEY A. LIFSEY/WIFE Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) FTLINCOLN CEMETERY 3/4/2011 BRENTWOOD, MARYLAND J. B. JENKINS FUNERAL HOME, INC. Ignature of Funeral Service 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine due to for eace nonsequence offi-If any, leading to immedit cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last nding physician and use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?
1 Yes 2 No Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed cate has been s ; page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of death? performed Yes 2 this certificate 1 Yes 2 No æ 25. Was case referred to medica 26. Place of Death (Check only one) director examiner? Hospital: 2 1 No Other: မ 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manual of Death funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d Describe how injury occurred After 5 Pending iniury Natural 2 Accident
3 Suicide
4 Homicide hin 24 hours after death the Funeral Director: A npleted filled in by the fo Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 only one 29b. Sign∎ture and tit<mark>le</mark> of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6777 201 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20832 ADLER 1310

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

32. Registrar Signatu

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 1:00p M Christine Kathryne Mook February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Heartfields Assisted Living Bowi.e 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 8. Date of Birth (Month, Day, Ye Julu 30. 1 M 2 X F Days Min Director 183-14-2282 87 Pennsulvania Usual Residence of Decedent show 10a. State 10h County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 7600 Laurel Bowie Road 20715 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🗓 No If Yes, Give "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 K No Specify. Specify. Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental I item 27 is marked o Kathryne Christine Doering Richard Fleming Dawson, III 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important: If item 27 is James R. Mook - Son 6501 Auburn Avenue, Riverdale, Maryland 20737 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) lington Natl. Cem. | 04/05/2011 | Arlington. Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. While <u> 11800 New Hampshire Ave., Silver Spring, MD 20904</u> 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac Arrythmia Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 ed by the attending prodetached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 X No 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure to Thrive of Vital Records, 1 Yes 2 No 3 Probably 4 XUnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Dementia autopsy performed? Yes 2 X No certificate 2 No 1 L. Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 X Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending injury 1 X Natural 5 Pending Division ithin 24 hours after death.

the Funeral Director: After ompleted filled in by the fun Accident 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On t (Check he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 Certifying Nurse oner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number D57028 February 18, 2011

Registrar

State

30. Name and address of person who completed

FEB 28

Aditya Chopra,
Date filed (Month, Day, Year)

M.D.

600 Ridgely Avenue, #231, Annapolis, Maryland 21401

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Feb. 2:30 A M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Beltsville 12507 Longwood Drive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) DC Feb. 27, Months Days Hours Min ^{Year)} 950 61 **Director** 578 66 9589 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Prince George's 1 XYes 2 No MD Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20705 12507 Longwood Drive. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
Black ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ano Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Claims Clerk Private/Dept.of Tred. 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked Margaret O'Neal William H. Cooper, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12507 Longwood Dr.Beltsville, MD 20705 Xavier Manley/Husband 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 3/2/2011 Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crem. 22. Name and Address of Facility Briscoe-Tonic Funeral Home Signature of Funeral Service License milelly 2294 Old Washington Rd.Waldorf, MD 20601 23a. Part 1, Enter the dise Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ğ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the g Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pendina s after death. 1 ☐ Yes 2 ☐ No Accider
Suicide Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29c License number 1010 who completed cause of death (Item 23a) (Type, Print) HIL 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201°1 5:15 M. February Gennie Martin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 5709 Blackhawk Drive Oxon Hill Age (In yrs. last birthday, 241-66-7853 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Hours Min. 1 9 - 9 - 1 9 3 9 Pelham, NC Director Usual Residence of Decedent show 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Oxon Hill 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 20745 10g. Citizen of What Country? United States 5709 Blackhawk Drive Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Al Hygiene. 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) P.G. County Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Food Service Manager permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Onza Harrelson Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oxon Hill, MD 20745 5709 Blackhawk Drive Stephanie Nunnally (Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 3/1/2011 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Low see Brentwood, MD 20722 3401 Bladensburg Road when 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1PLF Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consuluence of Exam that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 XNo Hospital: Other: 4 \square Nursing Home 5 ot M Residence 6 \square Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar KUMAR

DOSHI 32. Redistrar's 1701 LIVINGSTON ROAD

MD 206077

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 22 2011 PATRICIA В. MOSLEY 6:26 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S HOSPITAL PRINCE GEORHE'S CHEVERLY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday 1 🗆 M 2 🔀 F Months Days Hours APRIL Day Sear 1932 OHIO) 276-28-7982 **Director** 78 Usual Residence of Decedent 28a-f shov of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD PRINCE GEORGE'S BOWIE 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code Funeral 10900 SPYGLASS HILL ROAD 20721 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items and Injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12TH SOCIAL WORKER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CHARLES S. BAILEY ALBERTA SYKES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, REGINALD LASHLEY/GODSON 10900 SPYGLASS HILL ROAD BOWIE, MARYLAND 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Bernoval from State VETERANS CEMETERY 3/8/2011 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Solvice Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications to treate death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HYPERTENSION Medical Due to (or as a consequence of) **Examiner** CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on SEIZURE DISORDER physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 burs after death.

To the Funeral Director, After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur the completed filled in the page 1 should be detached for use as the bur the completed filled in the control of t P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown Be Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 X No 1 ☐ Inpatient 2【 ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 🕅 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🚰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month, Day, Year)

2011

32. Registrar's S

GEORGE H. BONE M.D. 1100 MERCANTILE LANE SUITE #135 LARGO, MARYLAND 20774

Ling Li, MD 31. Date filed (Month, Day Year 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

State Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 Februa, Physician/ CHERI DENISE MARSH 0231 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death rince Prince Chevenly pita Hos 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sep 2, 1964 9. Birthplace (State or Foreign Country) Funeral 6 Sex 1 🗆 M 2 🖾 F VA 577-96-6024 Director 46 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Upper Marlboro Prince Georges 10e. Street and Number 10g. Citizen of What Country? Funeral USA 12302 Markby Court 20774 death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Black Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PG County Schools Guidance Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Christine Poindexter Lawrence Slaughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Kimbrough - Mother Upper Marlboro, MD 20772 14200 Farnsworth Lane #402 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 3-3-2011 Clinton, MD Signature of Funeral Service Licensee ²² Name and Address of Facility Funeral Home of Maryland, INC. Marine 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Diseas Physician/ disease or condition resulting in death) Medical Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes_ 2 ☐ No Month Day Year signed by the and be detached for 1 Yes 2 9 Onknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be lirector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work within 24 hours after death. To the Funeral Director: At 1 🗌 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated сопретен (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 1214 completed cause of death (Item 23a) (Type, Print) (and SALVENO 3041 31 Date filed (Month, Day State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pebruary 23 8:30 pm Mui Van Nguyen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 212 Curry Ford Lane Gaithersburg 9. Birthplace (State or Foreign Country) Vietnam 5. Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) March 12.1 7. Age (In yrs. last birthday) If Under **Funeral** 1 X M 2 □ F Months Director 220-35-4018 84 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No Gaithersburg Maryland Montgomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Curry Ford Lane 20878 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💆 No If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Military 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ung Van Nguyen Hinh Thi Nauyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4505 Lees Corner Road, Chantilly, Virginia 20151 Joseph Thang Nguyen - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Dorlation 5 Other (Specify) 02/28/2011 Silver Spring, Maryland Gate of Heaven Cem. of Funera Se 21. Signat r 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit Cause (Disease or i that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗶 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 😥 Residence 6 C Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending injury work?
1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation within 24 hours after death

To the Funeral Director; / 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 25, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman. 1355 Piccard Drive, #100, Rockville, Maryland 20850 M.D .. 31. Date filed (Month, Day, Year,

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State Registrar

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month FEBRUARY 26 2011 1:22 A M JOSEPH NWOSU Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours APRIL 26 CANADA Director 26 1984 578-29-0676 Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 AYes 2 □ No MD PRINCE GEORGE'S FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6721 DARKWOOD COURT 20747 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: BLACK If Yes, Give "natural", 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) nd Mental Hygiene marked other the 12TH CLERICAL CLERK PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ .. Page 1 and 2 should be f tment of Health and Menta tant: If Item 27 is marked jury or other traumatic ev IGNATISU NWOSU AUGUSTINA IGBOKO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM IGBOKO/UNCLE 6721 DARKWOOD COURT FORESTVILLE, MARYLAND 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 Burial 2 G 4 Donation 5 C Removal from State GATE OF HEAVEN CEME. 3/12/2011 Donation 5 Dother (Specify) SILVER SPRING, MARYLAND 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Servi 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause an each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of QUENCE OIL Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): SERTL Hospital or Attending Physician: Telaw equires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial LUPUS Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ Unknown 9 Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ ♣ Be 26. Place of Death (Check only one) Hospital မ 1 Thipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide
Homicide Investigation after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical 29a. Certifier 💪 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 281 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON ADVENTIST HOSP, TAKON A PARK, MD-20912 SHAMIM

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Physician/ 9:40 PM Leroy Rogers, Jr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olne-Cente Montgomer General omeny 5. Social Security Number 579–26–3137 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth Funeral 1 🗽 M 2 🗆 F Dave Min (Month, Day, Year) Director 83 Aug. Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Silver Spring Montgomery 5 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral USA 20904 13332 Locksley Lane . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 XYes 2 No If Yes, Give 1 Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify. Year or Dates. 1946-47 3 Widowed 4 Divorced any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Federal Government Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Claney James Leroy Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13332 Locksley Lane, Silver Spring, MD 20904 Mary R. Rogers/Wife item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of F Important: If ite 1 Burial 2 remation 3 Removal from St 2/28/11 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Preumone Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine e attending physician and and for use as the burial-transit Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown g Unknown P.O. | as been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of Yarlanson's 24a. Was an autopsy death? 2 X No 25. Was case referred to medical examiner? Division of Vital B B 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+ M. A. Mavanur 24/2011 1)0071314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

1AVANUR

31. Date filed (Month, Day, Year)

FEB 28 2011

18101 Prince Philip Drive, Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month TANLEY 2011 February 7:30A Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4715 Mayfield Place Pomfret 8. Date of Birth (Month, Day, Year) Charles If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days New Jersey Months Hours Director 151-46-1014 November Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Charles Pomfret 1 🗆 Yes 2 ី No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 4715 Mayfield Place 20675 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ≥ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Specify Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Elevator</u> Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H 2 permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. Donald Francis Riley, Sr. Marion Garey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Jane Riley/Wife 4715 Mayfield Place, Pomfret,MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Maryland Veterans Cem. 3/8/2011 4 Donation 5 Other (Specify) Cheltenham, Maryland Signature of Funeral Service Licensee M00945 ZAREHART-ECHOLS FUNERAL HOME, P.A. avis C 20646 St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) month Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 ☐ Unknown Completed 1 Yes 2 No page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy perform Physician: 25. Was case referred to medical examiner?
1 Yes 2 O Be 26. Place of Death (Check only one) Hospital 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify hours after death.

neral Director: After this
d filled in by the funeral di this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier

RB10+1

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Frank J. Ravenscroft Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Alleq. WM Regional Medical Center Cumberland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Funeral 7. Age (In yrs. last birthday) 8 Date of Birth Days M 2 | F Month, Day, Xea 6-19-30 Director 217-28-0712 80 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Alleg Westernport 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 Greene St 21562 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Paper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Ravenscroft Agnes Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Ravenscroft Wife Westernport, MD 21562 201 Greene St. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Philos Cem. 3-4-11 Westernport, 21. Signature of Funeral Service Licer 22. Name and Address of Facility Fredlock Funeral Home Piedmont, Tones St WV23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Severe Chromic Obstructive lung disease or condition Medical resulting in death) Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit hronic Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No Yes 2 X No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျပ 1 Tes 2 X No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12501 Willowbrook Road, Cumberland, MD Ardalan Enkeshafi, MD, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ROZIER LEASTER. Physician/ MICHAEL 201 1820 PM 02 Medical 4a. Facility Name (if not institution, give street and numb PRINCE GEORGIE'S HOST 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTER CHEVERL PGI DRIVE If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. Hours OCT Day, 1 🖳 M 2 🗆 F WASHINGTON, DC 1944 Director 217-44-9081 66 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Examiner must be notified Yes 2 No MD PRINCE GEORGE'S UPPER MARLBORO ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12700 WATER FOWL WAY 20774 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 'natural", or Completed by 1 Never Married 2 XMarried 2 □ NoARMY Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 XNo Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates traumatic event, the Me lical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) filed within 12th AUTO BODY FENDER REPAIRMAN PRIVATE is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil rtment of Health and Mental rtant: If item 27 is marked or jury or other traumatic ew and Mental ဂ္ LEASTER ROZIER KATHERINE HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES_L. ROZIER/WIFE 2700 WATER FOWL WAY UPPER MARLBORO, MARYLAND 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MD VETERANS CEMETERY 3/2/2011 4 Donation 5 Other (Specify) CHELTENHAM, MARYLAND J.B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DIO RESPIRATOR Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 4POTENSION Secure tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. CACHEXIA and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical CARCINOMA WITH LIVER METASTASI DUCT Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death Yes 2 No the g 🗌 Unknown be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Mo 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available 24a, Was an has prior to completion of cause of death? **Director:** After this certificate I in by the funeral director, page 2 No 1 Yes 25. Was case referred to edical Be 26. Place of Death (Check only one) 2 No Hospital: Certificate: To 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 4725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHR DRIVE NAYA 98 31. Date filed (Month.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 26, 2011 11:10 AM Melba Jean Scarcelli Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg 17013 Beechers Avenue SW If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours November 28, 1939 71 220-38-5854 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Frostburg 1 X Yes 2 No Allegany 10e. Street and Number 17013 Beechers Avenue SW 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 21532-13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) homemaker homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Walter Hammonds St Dorothy Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21532-17013 Beechers Ave. Frostburg Maryland Francis Scarcelli 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Maryland Veteran's Cemetery 1 Burial 2 Cremation 3 Removal from State Flintstone Maryland March 01, 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Euperal Service Licensee Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SQUAMOUS CELL CARCINOMA LUNG Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) 2009 Due to (or as a consequence of): 0 **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-trans and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Dther (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year Pregnant at time of death the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has page 2 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D902337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12502 WILLOW Brook Rd. Swite 3 Zamar Suite 300 Cumberland

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 0 1 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State Registrar		S	State of M	larylan		artmen <i>tificate</i>			and N	/lental Hy	/gien Reg. N	20		0820	7
Physicia	n/	1. Decedent's Name		e, Last)		1				, outin	-	2. Date of De	eath		Year	3. Time of Death	
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Examin	er	Allegany	7 Healt	h Nur	sing &			(Cumbe	Location erlar	nd			lc. County o	lleg		
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and show	or	Usual Residence of 10a. State	Decedent 10b. County			10c. Cit	y, Town or Lo	cation							1	0d. Inside City Limits	,
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Eugene E				,						al Route Numbe				^{Code)} 2 1 502	
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Medical Examiner		disease or conditio resulting in death)	on	a	Due to (or as			WE		q	1 -				+		_
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	_	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 9 9 ☐ Unknown	months?	-	f yes, outcome 	2 Feta	l death 3	Ectopic p Other (sp		у				23d. Date Mon		ery Day Year	
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Hospital 24 hours Funeral eted filled	edical	(Check 2	Medical E	xaminer: 0	To the best o	examination	and/or invest	igation, in r	ny opinio	n, death c	occurred at	the time, date	and plac	ce, and due	to the cau	use(s) and manner state	ed.
	Σ	only one) 3 290: Signature and t			actioner: To the	PA L			License		e and plac	e, and due to tr		ate signed			_
5		30. Name and addre	ess of person	who comple	eted cause of o	leath (Item	23a) (Type, P	rint)	KI	31	<u>(QC)</u>	and	114	2/219/ 2007	111	ລ	_
Stat	e	31. Date filed (Month	h, Day, Year))	32. Registr	ar's Signat	Me /	St	lie	mk	erle	and	1001	<i> </i>	ال	<u> </u>	_
Registra	ır	F	FRSD	2011	Derw	غر به	1. Gear	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 3, Day 2011 **Physician** 3:15 Ам Lillian C. Starr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Garrett Grantsville 175 Parkview Circle Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 🕅 F Maryland 1925 85 Oct. **Director** 212-22-6305 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Punta Gorda Charlotte 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 33983 1512 Rio De Janeiro Ave. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Department of Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12 Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Keefer Dennis Corrick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 189, Grantsville, MD Suzanne C. Beachy/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Country Side Crematory March 4, 2011 Davidsville, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses D. Li P.O. Box 275, Grantsville, MD rem 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) week **Physician** Wasocomiz /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) mona burial-trar Due to (or as a consequer of): physician Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗓 No 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> in deline 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an Secono autopsy hypertrylyearsle 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 i 24 hours after death.

Funeral Director: Af letely filled in by the fur within 24 hor To the Fune completely fi

Certification: To 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

D0061801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

311 N. 4th St., Oakland, MD Kenneth Buczynski,

Registrar

10

31. Date filed (Month, Day,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death March 1, Day 2011 Year Physician/ Joyce Ann Spiker 12:17 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Devlin Manor Nursing Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months July 11, 1964 Days Hours Pennsylvania **Director** 46 210-60-9129 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Meyersdale PA Somerset 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 15552 215 Livengood St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Never Married 2 Married Completed by Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Merkle Response Data Entry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Martha Bittner Calvin Spiker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Livengood St., Meyersdale, PA 15552 Courtney L. Wilt/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State March 4, 2011 Salisbury, PA 4 Donation 5 Other (Specify) Salisbury Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 116, Salisbury, PA Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ donellear Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 4 Pregnant g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Ro 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an performed' After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4—Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

A JBOILING

32. Registrar's Signature

921 N2+

DUU17565

29d. Date signed (Month, Day, Year)

L2ULLE MD 21504

- 3. 201L

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 23e per med cert state of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea Not 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FEB . Day 23 2011 Physician/ FLOYD EDWARD TAYLOR 11:50 BM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** *GILCRIST HOSPICE CARE* TOWSON BALTIMORE Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min. APR. Ty Year 921 224**-**12-5669 1 🔀 M 2 □ F 89 BALTIMORE Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director *VIRGINIA* 1 Yes 2 XNo NORTHUMBERLAND REEDVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 71 FOX POINT ROAD 22539 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 💢 No Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🛣 No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CHAUFFEUR PRIVATE RESORT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HAMPTON TAYLOR ROSIE ROBERTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEWART TAYLOR (SON) 2506 CREEKSTONE CT. BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, XBurial 2 Cremation 3 Removal from State SHILOH BAP. CH. CEMETERY 3/5/11 REEDVILLE, VIRGINIA ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BERRY O. WADDY FUNERAL HOME ature of Funeral Service Lice 6784 MARY BALL RD LANCASTER, VA 22503 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ water Medical resulting in death) as a consequence of): Due to (or Examiner Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a con) equence of) -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1- Yes XX No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 No Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No. Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after To the Funeral Direc determined City or Town, State) Medical 29a. Certifier 📬 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a d title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.C horus ALLAIS TONISON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State were. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month <u>Helen C. Tabor</u> February 2011 6:30 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Morningside Assisted Living Waldorf Charles 9. Birthplace (State or Foreign Country) Connecticut 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Social Security Number Funeral (Month Day, Yea Days 1 M 2 X F Hours Months Director 88 Yrs 043-14-6124 lan. Usual Residence of Decedent 23a or 28a-f show ir than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11517 Timberbrook Drive 20601 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ည Mary Iskra Kuzma Cherlbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 11517 Timberbrook Dr. Waldorf, Maryland 20601 <u>Cvnthia Miller/ Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Vet's Cem. March 7, 2011 Cheltenham, MD 22. Name and Address of Facility 21. Signature of Funeral Service License Huntt Funeral Home Ju. 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed that initiated events resulting in death) Last ng physician ar as the burial-t Physician/Medical IF FEMALE: use yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No ò Month Pregnant at time of death 1 Yes 2 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Physician: The law performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work' 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Box 68760 P.O. Records, within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I **Division of Vital** Hospital or Attending To the I within 2

State Registrar 29a. Certifier

only one) 29b. Signature and title

and address of pe

certifier

completed cause of death (Item 23a) (Type, Print) Surveille Pd. # 201 A 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1 1 1 8 2 1 2												
			Registrar	Certificate of Death		Reg. No.									
	Physicia Medic		Decedent's Name (First, Middle, Last) JOSIAH AGBOR TAKANG		2. Date of Death Month February	Day 24, Žear 1	3. Time of Death 1 6:02 P M								
	Examin	er	4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death		Prince	George's								
	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 I F 7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth Month Day Year JAN 1 193	9. Birt	hplace (State or Foreign Intro EROON								
P	t t	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location			10d. Inside City Limits								
Aarylan	8a-fsh tifieda	recto	MD PRINCE GEORGE'S LAUREL	Location			1 Yes 2 No								
ith the N	23a or 2 st be no	Funeral Director	10e. Street and Number 11703 TRADEWIND TERRACE	10f. Zip Code 20708	, i	Citizen of What Co	untry?								
eath w	tems 2	Fune	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - Amer									
nd 21215-0036 fled within 72 hours after death with the Maryland	nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【X No If Yes, Give Year or Dates.	1 ☐ Yes 2X☐ No Specify:	ritoari, etc.)	Black, White	LACK								
15-0 12 hour	"natu edical	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation ive kind of work done during most of work	ing 16b	. Kind of Business I	ndustry								
2121 within 7	jiene. er than the M		Elementary/Seconday (0-12) College (1-4 or 5+)	e. DO NOT use retired) ACCOUNTANT	P	PRIVATE									
© 9	Mental Hyg a rked othe a tic event ,	To Be	17. Father's Name (First, Middle, Last) DAVID TAKANG	18. Mother's Nam	e (First, Middle, Malde FAKANG	en Surname)									
ary	alth and Mer 27 is marker r traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Rura	il Route Number, City	or Town, State, Zip	Code)								
e, ₹ and 2 a	Heal em 2 ther			703 TRADEWIND TERRA		Location - City or									
imor Page 1	0			riematory or other place) PLOT 3/26	/2011 MA	MFE, CAME	ROON								
Balti permit.	Department Important: I any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility J. 7474 LANDOVER ROAD											
	ш		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death								
1	ysician/ Medical	ê V	Immediate Cause (Final disease or condition resulting in death) a. Septic Shed Due to (or as a consequence of):				Onset and Death								
Ε)	xaminer	er	Sequentially list conditions, if any, leading to immediate b. Bowel Ische Due to (or as a consequence of):												
cuted	nd ransit	dical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	ulus											
be exec	sician a burial-t	cal E	resulting in death) Last Due to (or as a consequence of):												
3760 ficate b	g phya as the		US SERVICE				-								
. Box 687 le death certific	24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year								
S, P.O. res that the	signed by d be detac		Part II. Other significant conditions contributing to death but not resulting in the Diabetes Mellitus	he underlying cause given in Part I.			the cause of death?								
ord w requ	ss been 2 shoul	Completed by	Hypertension		24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of								
Rec	icate has				performed 1 Ves 2										
Vital /sician	s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No Hospital: 1 📈 Inpatient 2 ☐ ER/Outp	26. Place of Death (Check atient 3 DOA Other:	<i>conly one)</i> ome 5 ☐ Residence	6 ☐ Other (Spec	ifv)								
n of	er death. ector: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 □ Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 28b. Tim (Month, Day, Year)	e of 28c. Injury at	28d. Describe how in										
Division of Vital Records, talor Attending Physician: The law requires	after dea Director in by th∈	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,								
D Hospita	within 24 hours after To the Funeral Direct completed filled in by	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the basis of examination and/or in only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, de	vestigation, in my opinion, death occurred a	the time, date and pla	ace, and due to the	cause(s) and manner stated.								
To the	vithir To the comp	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	n, Day, Year)								
Š	~		30. Name and address of person who completed cause of death (Item 23a) (Typ	D 69430	Van Du rel. Mi	brudry Por	24, 2011								
R	3		Nega Ali Goji, MD Laurel Region		rel Mi	D 2070	07								
	Stat Registra	MICHAEL TO THE TANK AND													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Gerald Howard Tarbet 1:40 Рм 2011 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Woodside Center Nursing Home Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) Funeral 1 🖾 M 2 🗆 F Months Hours 299-24-1938 81 Director 1929 September 8. Youngstown, Ohio Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Ħ Director notified 28a-f 1 K Yes 2 No Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o "natural", or items 23a o with 1 Funeral USA 5813 Ruatan Street 20740 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11 Marital Status Armed Forces ve 1963–1968 þ 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. er than "natur , the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ulth and Mental Hygiene.
27 is marked other than r traumatic event, the Me within 7 Elementary/Seconday (0-12) College (1-4 or 5+) NASA 12 Communication Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thrent of Health and Mental rtant: If item 27 is marked injury or other traumatic ev ည James F. Tarbet Sadie Sheridan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey S. Tarbet / Son 329 Bay View Drive, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State 3/7/2011 Cheltenham, Maryland 4 Donation 5 Other (Specify) Maryland Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Prysician/ Metastatic Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Gastric Ulcer Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical P.O. Box 68760 phy: ending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Other (specify) Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed det <u>\$</u> Records, Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has Sate 1 Yes 2 No Yes 2 X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death e Funeral Director: A bleted filled in by the fi ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State

State

within 24 hor To the Fune completed fi

DHMH 17 Rev 7/2009

Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of certif

31. Date filed (Month,

MAR 0 1

3 [

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tanyech Patricia Walford, 1245 Eastern Blvd., Baltimore, MD 21221

👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25, 2011 February 0005 Lottie W. Tunstall Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, **Funeral** 1 🗆 M 2 🖾 F Min. North Carolina Days Hours Months Director Feb. <u>579-32-4052</u> Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Washington DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 20019 1009 Chaplin Street SE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Man College (1-4 or 5+) Elementary/Seconday (0-12) Government Clerical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Geneva Williams Joseph Rodwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Washington, DC 1728 40th Street SE Patricia D. Tunstall - Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington
ational Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 3/22/2011 4 ☐ Donation 5 ☐ Other (Specify) <u>Arlington, Virginia</u> 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Si ature of Funeral Service nsee 20019 Benning Road NE Washington, DC 23a. Part & Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AYAL Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine PER TENSION Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed 1 ☐ Yes 2 ☐ No After this certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🔀 No ျ 1 Inpatient 2 X ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practices: To the basis of my the 29b. Signature and title of certific 29c. License number

Registrar
DHMH 17 Rev 7/2009

10

State

30. Name and address of per

31. Date filed (Month, Day, Year)

2 2011

DAVIS

DR

on who completed cause of death (Item 23a) (Type, Print)

32. Regisar's Sig

J.1.4.1.4.1			For State	Certifica	ate of	Death				eg. No.		
Р	hysicia		egistrar . Decedent's Name (First, Middle,Last)		_			l N	Date of Dea Month	Day	Year	3. Time of Death 0328 hrs
	Examir		BUSHURAH AYODELE TOW	OLAWI				F	ebruary	24, 2011		
		4	a. Facility Name (if not institution, give street and number)		4	b. City, Town, or Lo	ocation of I	Death			inty of Dea	
			Doctor's Hospital			Lanham						
F	uneral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birl	hday)	If Under 1 Year	If Under:				For	Birthplace (State or eign NIGERIA
	rector		578-29-7215 1XM 2 F 63		Yrs.	Months Days	Hours	3	SEPT.	14 19	4/	Country)
			Jsual Residence of Decedent									10d. Inside City Limits
	È	T	0a. State 10b. County	10c. City, Town	or Location	on						1 X Yes 2 No
-0	Po A		MD PRINCE GEORGE'S	LAN	MAH							
rylan	28a-f show any d at once.	왕	10e. Street and Number	-		10f. Zip Code				10g. Citizen		ountry?
hours after death with the Maryland	or items 23a or 28a-f sho must, be notified at ouce.	Director	9871 GOODLUCK ROAD T-2			20706				USA	7	
ith th	, 23a		11. Mantal Status 12. Was Decedent	er in U.S.	13. Wa	Decedent of Hisp	anic Origin	n? (Specif	y Yes or No		Race - Am White, etc	erican Indian, Black,
ath w	is tem	Funeral	1 Never Married 2 X Married Armed Forces?	No	lf Ye	es, specify Cuban,	Mexican, F	Puerto Rica	an, etc.)		vviite, oto	
er de			3 Widowed 4 Divorced If Yes, Give Year		1	Yes 2X No	specify:				cify: BL	
ırs afi	"natural", Examiner	ğ	15. Decedent's Education (Specify only highest grade com	pleted) 16a.	Deceden	t's Usual Occupationst of working life. I	on (Give ki	nd of work	done	16b. Kind	of Busines	ss/Industry
2 hor		촱	Elementary/Secondary (0-12) College (1-4 or 5	+)					'			
36 hin 7	edica e	힐	12TH		RESI	DENT ASSI	STAN	Γ			IVATE	
9	Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)							Maiden Sur		1 A
21215-0036	ked H	Be	SHANUSI TOWOLAWI				ASHI			RTHY-0		
9, MD 21215-0036	perint. Tages I am a source of the perint. The perint of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	힏	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (Street	and Numb	per or Rura	al Route Nu	mber, City o	riown, St Mr.A.D.V.T	AND 20706
M S	h and 27 is		NURUDEEN O. TOWOLAWI/SON						ate	NULTANIA I	etion - City	AND 20706 or Town, State
6	Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Sta		of Dispos tory or oth	ition (Name of cem ner place)	letery,	D.	ale			
D S	nt of	J		FAMI	LY P	LOT		3/12/	2011	IJE	BU-OI	E, NIGERIA
Baltimore,	Department of F Important: If injury or other	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		22. N	lame and Address	of Facility	J. E	B. JEN	NKINS	FUNE	RAL HOME, INC.
8	ii ii ba		X. N. M-hall		7	474 LANDO	OVER	ROAD	HYAT	CSVILL	E,MAI	RYLAND 20785
Phy	ysician	\neg	23a. Part I. Enter the disease, or complications that caused	the death. Do r	ot enter t	ne mode of dying,	such as ca	rdiac or re	spiratory a	rrest, shock,	or heart	Approximate Interval Between Onset and
* /N	ledical		failure. List only one cause on each line. Immediate Cause (Final disease a. Pulmonary Thro	mboemboli	sm							Death
Ξxa	aminer		or condition resulting in death) Due to (or as a conse						_			
			Sequentially list conditions, b.									
		ner	if any, leading to immediate Due to (or as a const	equence of):								
		Examine	(Disease or injury that initiated events resulting in death) Last	equence of):								
3	ted d ansit	E	d.									
	cate be executed physician and the burial - transit	Medical	UNPENDED AMENDED									
60,	te be nysici buri	질	IF FEMALE: 23c. If yes, outcome	ne of pregnanc	у						ate of del	
87	tifica ng ph as thu		23b. Was decedent pregnant in the		~		Ectopic	pregnanc	У	Mo	onth	Day Year
Box 687	that the death certifi- ned by the attending detached for use as t	Physician/	4 Pregnant at	time of death	5 O	ther (Specify)						
& -	e dea the a ted fo	hys	Part II. Other significant conditions contributing to deal	h but not recult	ing in the	underlying cause 0	iven in Pa	ırt İ.	23e. Did	tobacco use	contribut	e to the cause of death?
P.O.	hat th ed by letach	by P	Part II. Other significant conditions contributing to deal	II Dat Hot result	ing in the	underlying sales g			1 🗆 Y	es 2 N	lo 3	Probably 4 🗹 Unknown
D.	iires that signed d be deta							_	24a. Wa	is an		e autopsy findings available
Ę	w requir s been s should b								aut	opsy formed?	prio deal	r to completion of cause of th?
ည္မ	ne lav ite ha ige 2	ıE								2 No	1	Yes 2 No
<u> </u>	certificate ector, page		25. Was case referred to medical			26.Place		(Check on	ly one)			
Division of Vital Records,	hysicia this cer I direct		examiner? 1 Yes 2 No Hospital: 1 Inpati	ent 2 🗹 ER	Outpatier		Other ₄		Home 5	Residenc		Other:
5	After th	5.	27. Manner of Death 28a. Date of Inj (Month, Day,		. Time of		ry at Work		8d. Describ	e how injury	occurred	
5	ath. Pr: A he fu	ţį	1 V Natural 5 Pending				Yes 2					0.1
<u>:</u>	r Attender death	Ea	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of I	njury - At home	farm, str	eet, factory, office b	ouilding, et	tc. 2	8f. Location or Town		Number o	or Rural Route Number, City
Š	ital ours after a Direction	Certification	determined (Specify)									
	Hosp 24 hou Fune	2	29a Certifier . De us to Bhostofa. To the heat of s	ny knowledge, o	death occ	urred at the time, d	ate and pla	ace, and di	ue to the ca	ause(s) and i	manner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burincompletely filled in by the funeral director, page 2 should be detached for use as the burin	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner stated	amination and/o	r investig	ation, in my opinior	n, death oc	curred at t	ure ume, da	ate and place	s, and due	to the cause(s)
	# ¥ ¥ §	₹	29b. Signature and title of certifier			29c. Licens					_	(Month, Day, Year)
			Aller Brull MI)		O.C.	M.E.			rebru	ary 24,	2011
			30. Name and address of person who completed cause of	death (Item 23	a)							
R	6		Melissa Brassell, MD Assistant Medica			N. Baltimore S	Street, B	Baltimore	e, MD 21	223		
7		State	31. Date filed (Month, Ray Year) 32. Registr	r's Signature	41							
			MAR 0 2 2011 Cenua	7 ATA 12 .	100							

permit. Page 1 and 2 should be filed within 72 hours after death Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	For	Pleas	se Type or Pri State of M							-		_	ble.	
	For State Registrar			,	•		te of D				Reg. No		1 1	00010
an/ cal	1. Decedent's Name Karl L. W		_ast)						2	. Date of Dea	ath	ZU	Year	3 Jime of Death
er			ive street and number)	Cente	r	4b. City		Location of De			40	. County of		<u> </u>
	5. Social Security No. 214-07-54	umber 6			st birthday) Yrs.	If Unde Months	er 1 Year	If Under 24 H	_	Date of Birt (Month, Day January	h (<i>Year</i>) (05 , 1	910		place (State or Foreign try)
for	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation				•				0d. Inside City Limits
Funeral Director	Maryland 10e. Street and Nun	Alleg	any Mount Savage I		stburg J W	10f. Zi	p Code	_			10g. Ci	itizen of W	hat Coun	1 ☐ Yes 2 🛣 No
unera	11. Marital Status		12. Was Decedent E	· · · · · · · · · · · · · · · · · · ·	13. \	Nas Dece	532- dent of His	panic Origin?	(Specify	/ Yes or No-	U.S		- America	an Indian,
by	1 Never Marri		Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No			cify Cuban 2 ☑ No	Specify:	uerto Ric	an, etc.)			, White, e	etc.
Completed	(Spe		s Education grade completed) College (1-4 or 5	i+)	16a. Deced (Give I life. De	dent's Usu kind of wo O NOT us	ork done di	tion uring most of u	working			Kind of Bus		
Bec	8		0	.,	spinn	ing de	ot. time					ric mai	nufact	urer
To B	17. Father's Name (I				,			18. Mother's I			Maiden	Surname)		
	19a. Informant's Na Stanley E.	we/Relationship			19b. Mailir 452 N. ¹	_		nd Number or Ce (oute Number erland	; City oi	r Town, Sta Maryl		21502-
: 918	20a. Method of Disp 1 🗶 Burial 2 l 4 🗌 Donation		Removal from State	C	lace of Dispo emetery, cren rostburg 1	natory`or	other place		Date March (9 01, 2011		ocation - (wn, State faryland
	21. Signature of Fur	neral Service Lic	ensee	1	22			of Facility	57 Fr	ost Ave.,	Fros	tburg.	MD 2	1532
ical Examiner	Immediate Cause (disease or condition resulting in death) Sequentially list conif any, leading to improve cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, imediate tying injury	b. Due to (or as a Due to (or as a d	consequ a consequ	ence of): ence of):	ic 0	bstw	ctive	Rul	monnt	y Di	iseus-	e.	Interval Between On et and D. ath
Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Fetal	death 3	Ectopic Other (s	pregnancy pecify)	,				23d. Date Mon		ery Day Year
by		1	contributing to death b			nderlying	cause give	en in Part I.						e cause of death?
Completed		J				_				24a. Was a	an sy med?	24b. W	ere autop ior to coreath?	osy findings available impletion of cause of 2 No
m	25. Was case referre examiner? 1 Yes 2	ed to medical No	Hospital:				Other	ce of Death (C						
cate: To	27. Manner of Death	5 Pending	28a. Date of inju (Month, Day	у	ER/Outpatien 28b. Time of injury		28c. Injury work?	4 Nursin at	28d	5 Resid				1
Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigat 6 Could no determine	t be 280 Place of Inju					<u> </u>		Location (S City or Town			or Rural	Route Number,
Medical	(Check 2	Medical Exa	nysician: To the best of miner: On the basis of ex urse Practioner: To the	kamination	and/or invest	igation, in	my opinion	, death occurr	red at the	time, date ar	nd place	and due t	to the cau	ise(s) and manner state
	29b. Signature and t	itle of certifier	Shi MI)		29	c. License	number	-5	1	29d. Da	te signed	(Month, E	Day, Year)
	30. Name and addre	ess of person wh	o completed cause of do	eath (Item	23a) (Type, P	rint)	Cu	mber	ama	d MD	215	02	(- 11
te ar	31. Date filed (Month	28 201	32. Registra	r's Signati	park	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2011 4:20 P M Herbert. D. Weintraub Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Country)
New York If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral Social Security Number 1 **X** M 2 □ F Days Hours Yrs Director 109-22-5339 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 No Maryland Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5600 Wisconsin Avenue. 20815 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by ò 1 Never Married 2 X Married timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Medicine Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Schwartz Weintraub Pauline Aaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5600 Wisconsin Avenue, #807 Chevy Chase, MD 20815 Judith Weintraub. Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation Department o Important: If any injury or Removal from State 2/27/2011 4 ☐ Ponation 5 ☐ Other Specify) Judean Mem. Garden Olney, Maryland Signature of Funeral Service Lice see 22. Name and Address of Facility Hines-Rinaldi Funeral Home, M00709 11800 New Hampshire Ave., Silver Spring. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line. 29a. Part 1. Enter the dis shock, or heart ailu Immediate Cause (Final Approximate Interval Between Onset and Death Physician Atherosclerota disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): as the burial-transi Due to (or as a consequence of): resulting in death) Last sate has been signed by the attending physician page 2 should be detached for use as the burial certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 9 🗌 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes Yes mpleted filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural $5 \square$ Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Set trying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature and title of certifier D66896 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814 Matthew Madison Leonard. M.D.,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February 2011 12:00 PM Jesse Guy Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 13113 Eddington Drive Upper Marlboro Prince George's Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Unde Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Months **Director** 579-28-5936 Yrs 85 DC Dec. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Upper Marlboro Maryland Prince George's 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r Funeral 13113 Eddington Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: African 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th General Services College (1-4 or 5+) Administration Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jesse Wright Missouri Silas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Wright - Daughter 13113 Eddington Drive Upper Marlboro, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Maryland
eterans Cemetery 1 M Burial 2 Cremation 3 Removal from State March 1 2011 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Glioblastoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the and be detached to Unknown Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed After this certificate 2 No Yes 2 X N 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury **X**Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours are death Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and add

MAR O

31. Date filed (Month, Day, Yes MAR 0 1 2011

Zama,

MD

20774

largo, Md.

9200 Basil Court Suite 22

on who completed cause of death (Item 23a) (Type, Print)

32. Registar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 24, 2011 Carl Edward Whorton 12:05 Ρм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3279 Accident-Friendsville Rd. Accident Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** OCL. 18, , 1924 Maryland 1 1 M 2 D F Months Days Hours Min. Director 213-22-3071 86 Usual Residence of Decedent f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 23a or 28a-f sho amportant: If item 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Garrett Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21520 USA 3279 Accident-Friendsville Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) State of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) DHMH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည (unknown) Virginia Belle Whorton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan L. Whorton/son 3279 Accident-Friendsville Rd., Accident, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State St. Paul's Luth. Cem. March 1, 2011 Accident, MD 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARKIN 29 disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury that initiated events Exami burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial /Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed this certificate 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera injury Natural 5 Pending 1 Yes Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number igned (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and address of person who Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR -2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Worth Physician/ Year 140R.M artoto Doci Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 6. Sex Baltimore 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Hours 241-56-2192 NC Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore MD NA Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be i 2401 Gainsborough Court 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etAfrican δ 1 Never Married 2 Married 5-0036 1 Yes 2 No Specify: Specify: American If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Doctor Office 12th Grade Dental Assistant Be Maryland; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Paul Ben Alston Mattie Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reggie Anderson-Son 4207 Belvieu Avenue Baltimore, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Western Star Cem 03-22-11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home P.A. Signature of Funeral Service License Street Baltimore, MD 21217 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ CV disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Lisease or imjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of autopsy perform death? within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 2 No 2 XN Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASH WHARAN bood 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registr*a*r Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Richard Bowen March 2011 03:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 701 Waterview Drive Baltimore Anne Arundel 8. Date of Birth (Month, Day, Year) Jan. 02 1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ▼ M 2 □ F 220-64-9393 Director 55 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Waterview Drive 21226 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1

Yes 2

No. Black, White, etc. 1 Never Married 2 A Married ģ Baltimore, Maryland 21215-0036 er than "natural", the Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Glazer Glass Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Richard F. Bowen Sr. Regine Andrews permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve V. Bowen (spouse) 701 Waterview Drive, Baltimore, MD 21226 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 4 Donation 5 Other (Specify) Baltimore, Maryland 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ ever noma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the at a be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Des 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, § 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) PASADENA 8021 RITCHIR CYRIAC 32. Registrar's 9 gnature 31. Date filed (Month, Day, Year) State Registrar

Box 68760

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygien 2 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ owen 2:45/+M 2011 Medical 4a. Facility Name (if not institution, give str 4b. City, Town, or Location of Death 4c. County of Death **Examiner** izabeth Baltimor WISING Center 8. Date of Birth 6. Sex 7. Age In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day Sept 20. Country) Maryland 1 M 2 X F 220-78-2524 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director Glen Burnie Anne Arundel Maryland 1 Yes 2 x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21061 403 West Ordnance Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status rmed Forces? Black, White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: "natural", Completed 3 XWidowed 4 Divorced White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. 2 James E. Denney Mary E. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George M. Gunther (Nephew) 1764 West Drive, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Glen Haven Memorial Park | Mar 18, 2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kevin E Ecker 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Examiner nhaa Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No rate has been signed by the atterpage 2 should be detached for a Day Year 5 Other (specify) Month Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nemi 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Mapper of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 320 enue 32. Registraris Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bratcher 2011 9:05 P.M William Joe March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Co. Glen Burnie 1250 Aster Drive If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 1**X** M 2 □ F Months Davs Hours Country) 216-30-9085 75 Director 1935 Tennessee April Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Marken Exercises. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 XNo MD Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 1250 Aster Drive 21061 United States 12. Was Decedent Ever in U.S.

Armed Forces?

1 ▼Yes 2 □ No 1953 −

If Yes, Give
Year or Dates. 1957 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Linen Rental Co. Founder & Owner 9 yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Georgia Juanita Harris Bratcher 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1250 Aster Drive Glen Burnie, MD Mrs. Nancy L. Bratcher / wife 20a. Method of Disposition
1 ⅔ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD Veterans Cemetery 03/18/2011 Crownsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 • M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructur disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to lor as a consequence of If any leading to immedicause. Enter Underlying and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No ed by the a 9 Unknown s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy autopsy performed? 2 No page death? 1 ☐ Yes 2 ☑ No certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) ral director, Be examiner? Hospital 2 🗹 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Aft
bleted filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 050108 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Outwood

32. Registrar's Signature

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Michael Downing

31. Date filed (Month, Day, Year)

21061

Wen Burnie

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles Edward Barnhill March 10 2011 12 :10^Ma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death **Examiner** Ivy Hall Nursing Center Middle River Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 247-42-7887 1 → M 2 □ F 80 May 11,1930 SC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Must: If Item 27 is marked other than "natural", or Items 23a or 28a-f show mixt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at Baltimore Essex 1 ☐ Yes 2√2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 947 Homberg Avenue 21221 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? ★★]Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡No Specify. White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GM Lineman Repair 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Barnhill ၉ Willie Underwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Barnhill /wife 947 Homberg Avenue Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If It any Injury or c 1 Burial 2 □ Creymation 3 □ Removal from \$tate owings Mills MD 4 ☐ Donation 5 ☐ Other (Specify) 03/18/11 21. Signature of Fundal S 22. Name and Address of Facility 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease or comprisations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): mee disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical the as attending I IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a d be detached f ☐Yes 2☐No 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 14 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 No 1 Tyes 2□ No 1□ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 3∏ DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 □ ER/Outpatient ٩ this within 24 hours arer death.

To the Funeral Director: After thi completely filled by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: Injury 1 Natural
2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Thomicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person wh cor pleted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 1 6 2011

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 13:54 PM 201 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day Year) ARY 16,1936 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Mary land 219-32-7951 75 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Dundalk Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 23a or USA 21224 909 Dalton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 🕅 Married White 1 ☐ Yes 2 🕱 No Specify: <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City 12 years years Social Service Buyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Broda Emma Roberts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 909 Dalton Avenue, Dundalk, Md. 21224 wife Paula Broda 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the dis - se or complications that caused the lefth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 2 No 1 Tes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 - No 1 Tyes 2 ER/Outpatient 3 DOA ည this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No death. 2 Accident within 24 hours after death

To the Funeral Director: A
completely filled in by the f the 3
Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-00 Murh 14, 2011 30. Name a who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 11595

State

Registrar

MAR 1 6 2011

Baltimore, Maryland 21215-0036

Box 68760.

Records,

of Vital

Division

barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death 2. Date of Death 3. Time of Death Physician/ MARCH MARCH GUNTHER R. BORRIS 2011 4:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ENVOY OF PIKESVILLE PIKESVILLE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Days Hours (Month, Day, Year) **Director** 212-16-2599 92 GERMANY Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoring or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3412 MIDFIELD ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. WHITE Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTANT ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HANS BORRIS MATHILDA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH BORRIS / WIFE 3412 MIDFIELD ROAD BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4

Denation 5

Other (Specify) Donation 5 Other (Specify) CHEVRA AHAVAS CHESED ! 3/14/2011 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of ic Licensee 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SCPSI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Exami nding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? ģ Day Pregnant at time of death be detached 1 ☐ res ∠ ☐ 9 ☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an , has autopsy performed? Yes 2 No prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural work? 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homiċide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0061199 NOVE Charles St. Suite 4105, Touson, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar		epartment of l Certificate of			iene eg. No.	08228	
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	·		SEASONS HOSPICE @ 5. Social Security Number 6. S	BALTIN							
1	Funeral Director		215-84-7314	M 2 X F	n yrs. last birthda 89 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 02/13/1	922 9. Bi	rthplace (State or Foreign puntry) MD	
	and show 1 at	٥	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Location				10d. Inside City Limits	
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	ith the 3a or it be n	를	10e. Street and Number	DD TITE #01		10f. Zíp Code			0g. Citizen of What C	ountry?	
	eath w tems?	Funeral Director	3801 SCHNAPPER 11. Marital Status	12. Was Decedent Eve	r in U.S.	3. Was Decedent of H	lispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - Am	erican Indian,	
39	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 XXWidowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give	,	1 Yes 2XX No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi		
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ylaı	uld be I Menta narked natic e	은	ISRAEL	SOPHER		-	HILDA		TWA	ARKOWSKY	
	2 shu th ar 7 is trau	ı	19a. Informant's Name/Relationship (1 HELAINE MEYERS/	**	1	ailing Address (Street BOXRIDGE			City or Town, State, Z		
Baltimore,	ge 1 and 2 set of Health If item 27 or other tra		20a. Method of Disposition XX Burial 2 Cremation 3		20b. Place of Di	sposition (Name of prematory or other place			20c. Location - City o	r Town, State	
<u>ti</u>	Pag ant:		4 Donation 5 Other (Speci	fy)	-	NTEFIORE	CEM 03/1	5/2011	BALTIMOR	RE, MD	
Ba	permit. Departn Importa any inju		21. Signature of Funeral Service Licen	see		22. Name and Address 8900 REIS'	. 5		SON & BROS KESVILLE,		
ī			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the	e death. Do not					Approximate Interval Between	
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289	certific inding puse as	ın/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of de	elivery	
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<u> </u>	Physia r this c eral dire	<u>و</u>	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of injury	2 ER/Outpa		4 □ Nursing Ho	me 5 Resider	nce 3 Other (Spec	cify)	
ono	ending aath. or: Afte he fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye		/ work	Yes 2 No	zou. Describe nov	injury occurred		
DIVISION OF	l or Att after de Directe I in by t	Certi	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury -					(Street and Number or Rural Route Number, own, State)		
_	Hospita Hospita Hours Funeral ted filled	Medical	(Check 2 L Medical Exam	sician: To the best of my iner: On the basis of exam	nination and/or inv	estigation, in my opinio	on, death occurred at	the time date and	place and due to the	cause(s) and manner stated.	
	Fo the I within 2 Fo the I comple:	ž	only one) 3 Certifying Nur-	se Practioner: To the bes	t of my knowledg	e, death occurred at th	e time, date and plac	e, and due to the c	ause(s) and manner as	stated.	
)		· Chap of	SOIN	M	DIS	よフス	1	A		
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	Reint)	alus	1 5-	ido Ni	21061	
	Stat Registra	e ir	31. Date filed (Month, Day, Year) NAR 1 6 2011	32. Registrar's	Signature	Kel		04)			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3 Time of Death March 12 , 201 Tear **Physician** 6:00P.M Burkowska 0 Laura /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 728 Sue Grove Road Essex 8. Date of Birth Nov 15, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1940 Maryland 70 218-36-0244 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No Md. Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 728 Sue Grove Road 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than "other traumatic event, Inc. No. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Osman N. Chalk Erma F., Windsor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troonce. 728 Sue Grove Road Baltimore, Maryland21221 Edward Burkowske /Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchate 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 17,2011 |Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee Tolu Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Physician Cancer 15 mm Hac /Medical Due to (of s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Ent Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of); Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 14, 2011 124356

State Registrar

31. Date filed (Month, Day, Year)

WAR 1 6 2011

32. Registrar's Signature

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr.William C. Waterfield, M.D. 9103 Franklin Square Dr.Ste2200Baltimore

11-01940 Patrick Brusio

Pk

ease Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and	All Copies Are Legible 0	08230
Certificate of Death	Reg. No.	
ne (First Middle Last)	2. Date of Death	3. Time of Death

	1- For State Certificate of Death Reg. No.								
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year								
	4a. Facility Name (if not institution, give street an Harford Memorial Hospital	nd number)	4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford				
Funeral Director	5. Social Security Number 6. Sex 217–92–3660 X ₁ X _M 2	7. Age (In yrs. last birthday)		Ensoine					
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation			10d. Inside City Limits			
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with the Maryland ns 23a or 28a-f sho be notified at once.									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at sonce. To Be Completed by Funeral Director	1 X Never Married 2 Married Arm		/as Decedent of Hispanic Origin? (Si Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.				
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MD and 2 sho m 27 is aumat	Diane Brusio / Mother		Lynn Lee Dr, Aber		21001 Oc. Location - City or T	own State			
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Department in injury	(Leonin		Name and Address of Facility Carring-Cargo Fundadas S. Parke St,	eral Home Aberdeen,	MD 21001				
Physician /Medical	23a. Part I. Enter the disease, or complications to failure. List only one cause on each line.	that caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest,	, shock, or heart	Approximate Interval Between Onset and Death			
Examiner		rphine Intoxicat	ion			Death			
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tox 687 eath certificate a stending properties as the for use as the state of the s	23b. Was decedent pregnant in the	Drognant at time of death	Fetal death 3 Ectopic pregn	ancy	Month Da	ay Year			
). Box 68760, the death certificate be executed by the attending physician and exched for use as the burial - transparent Physician/Medical	4 Ves 3 No 9 Unknown	Pregnant at time of death 5	Other (Specify)						
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w requires to w requires to seen sign should be opleted to				24a. Was an autopsy		opsy findings available ompletion of cause of			
Division of Vital Records, P.O. tal or Atteodiog Physiciae: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl entification: To Be Completed by Fartification: To Be				performe	ed? death?				
tal Recident The certificate rector, page	25. Was case referred to medical examiner?		26 Place of Death (Check	only one)					
f Vit Physici or this c ral dire	1 Yes 2 No	Inpatient 2 ✔ ER/Outpatie Date of Injury 28b. Time of		ng Home 5 Re	esidence 6 Other:				
odiog Photh. T: After the funeral	1 Natural 5 Pending	(Month, Day, Year) d 3-11-11 fd 085	4 Van 3 Van		took morph	ine			
Division o spital or Attending nours after death. oeral Director: Aft filled in by the function.	Z ANA ACCIDENT INVESTIGATION L	Place of Injury - At home, farm, st		28f. Location (Stre	eet and Number or Run (e) 835 Lynn	al Route Number, City			
Diversity of the control of the cont	4 Homicide determined (Sp	ecify) reside		<u> Aberdeen</u>	, Md.				
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical E.	one) 2 Medical Examiner: On the b	ne best of my knowledge, death occ pasis of examination and/or investion oner stated.	curred at the time, date and place, and pation, in my opinion, death occurred	d due to the cause(sat the time, date an	s) and manner as state d place, and due to the	cause(s)			
F > F S F S	29b. Signature and title of certifier		29c. License number	1.	29d. Date signed (Mon March 12, 2011	th, Day, Year)			
	30. Name and address of person who complete	d cause of death (Item 23a)	O.C.M.E.						
8	Russell Alexander MD. Assista	ant Medical Examiner 11	1 Penn Street, Baltimore, M	ID 21201					
State Registrar		3. Registrar's Signature	Kel	00145					

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Coale 0630M Physician/ Month a th Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Westminster Carroll Hospital Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** August 19 1 🗆 M 2 🗶 F Hours New Jersey 140-32-2131 1942 Director 68 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director Hampstead 1 Tes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21074 4480 Woodsman Dr. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Admin. administrative assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edna Cochran George Malpass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Parcells/daughter Baltimore, MD 21212 736 Overbrook Rd. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory Mar. 17,2011 Baltimore, Maryland 22, Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 INO Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 - No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C 29a. Certifier 🖃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1)29502 MJ address of person who completed cause of death (Item 23a) (Type, Print) East Main street MA 31. Date filed (Month, Day, Year) Registrar

11-02005 Theresa Eder	ı Cala				of Health and Me		Legible,	2 Commence	08232
Physi		1. Decedent's Name (First, Mic	·		-	2. Date of Month	Day	Year	3. Time of Death 1817 hrs
Medical Exa	miner	Theresa Eden 4a. Facility Name (if not institu		ner)	4b. City, Town, or Location		13, 2011	County of Death	1017 1115
		Johns Hopkins Hosp		561)	Baltimore				
Funer	al	5. Social Security Number	6. S ex 7.	Age (In yrs. last birthday)			of Birth (MM/D	D/YYYY) 9. Birti Foreigi	
Direct	or	215-71-1676	1 M 2 X F	35	frs. Months Days Hou	rs Min. Apr	. 4, 19	975 Plan	Tippines
b		Usual Residence of Decedent 10a, State 10b, Count		10c. City, Town or Loc	odion				10d. Inside City Limits
OW Any			imore						1 Yes 2 No
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he Ma		4605 Riddle I)rive		21236		USA		
with ti	<u>a</u>	11. Marital Status	12. Was Deced		Was Decedent of Hispanic Or	rigin? (Specify Yes	or No-	14. Race - Americ	an Indian, Black,
death		1 Never Married 2 X	1 Yes	zes? 2 X No	f Yes, specify Cuban, Mexica			White, etc.	
after	niner must be no by Funeral		Divorced If Yes, Give Year or Dates:	1	Yes 2X No specificant's Usual Occupation (Give			Specify: Fili ind of Business/Ir	<u> </u>
2 hours	the Medical Exam	 Decedent's Education (Specific Elementary/Secondary (0-1) 		during	most of working life. DO NO	Tuse retired)	IOD. KI	ild of Edsilless/ii	iddali y
336 thin 72 than		12	4	Nurse	2		Nu	rsing	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f shoo	3 E	17. Father's Name (First, Midd		<u> </u>		er's Name (First, Mi	ddle, Maiden S	Surname)	
121 d be fi ental	Be It.	Arthur Sipaci		I 10h Mai	ing Address (Street and Nu	a Simpas	o Number Cit	v or Town State	Zin Code)
D 2 should and M	5 C	Allan C. Cala			5 Riddle Drive				
s, M and 2 lealth	T .	20a. Method of Disposition		20b. Place of Disp	osition (Name of cemetery,	Date	unk 20c. L	ocation - City or	Γown, State
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Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is	ury or	4 Donation 5 Other 21. Signat of Fune 8 S rvi	ce ticensee		. Name and Address of Facil	1	- 0		York Road
Der Der	Í	1 cm f	lay		ıck Towson Fui				n, MD 21204
Physicia /Medic		23a. Part I. Enter the disease, failure. List only one caus	se on eagh line.				ory arrest, shoo	ck, or heart	Approximate Interval Between Onset and
Examin		Immediate Cause (Final disea or condition resulting in death)	se / Comp1:		Labor and Del	ivery			Death
		Sequentially list conditions,	b.	orisequence or).					
	aminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence of):					
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State 31. Date filed (Month, Day, Year)
Registrar NAR 1 6 2011 DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

32. Registrar's Signature

OCME

11-01917

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard L. Dove State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Medical Examiner 1943 hrs Richard L. March 10, 2011 Dove 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1703 E. Baltimore Street Baltimore NA5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Months Director 074-40-9579 61 06-09-49 1XXM 2 F NY Country) Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 28a-f show 1 X Yes 2 No "natural", or items 23a or 28a-f sho | Examiner must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1703 E. Baltimore Street 21231 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 2 X Married 1 Never Married 1 Yes Specify: American 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade NA Executive Door man Marriott 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Herman Dove, Sr. Be Mary McCummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231Roslyn Dove-Wife 1825 E. Baltimore Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Rosenill Cem. 03-19-11 Linden, NJ Donation 5 Other Specify 21. Signature of Funeral Service Lig 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD nes Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and (Medical a. Liver Carcinoma Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last rand transit Physician/Medical UNPENDED AMENDED the attending physician ned for use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Heart Disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has performed? death? Yes 2 ✔ No 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural I Director: 1 Yes 2 No death Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner stated 29b. Signature and title of/certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME March 12, 2011 of person who completed cause of death (Item 23a) OCME Mary G. Ripple MD Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 9:46 PM March Walter James Davies Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Bel Air Upper Chesapeake Medical Center 8. Date of Birth (Month, Day, Year) Jan. 15, 1919 9. Birthplace (State or Foreign Country) Michigan If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex **Funeral** Min. 1 ★ M 2 □ F Months Days Hours Jan Director 363-12-9112 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e Street and Numbe items 23a Funeral USA 1514 Donegal Road 21014 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 🔀 Yes 2 🗌 No If Yes, Give Black, White, etc. o, Completed by 1 Never Married 2 Married 1 Yes 2X No Maryland 21215-0036 Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Colonel Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ Ina Mable Sommers Griffith Thomas Davies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1514 Donegal Road, Bel Air, MD 21014 Barbara C. Davies / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Decatur, Michigan 4 Donation 5 Other (Specify) Hamilton Cemetery 5-10-11 21. Signature of Funeral Service Ligenses McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, athleer Dantwasc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 9 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PINS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner es the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Sepsis physician and Due to (or as a consequence of): Physician/Medical Davies, Walter Mocolog30. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed Yes 2 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes ER/Outpatient 3 DOA ျ 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 > Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of mycknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29h. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per PHY 6913 3/16/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Emily T. Donaldson March 19ay 20^Yfan Physician/ 7:10a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel 1081 Crestview Drive 9. Birthplace (State or Foreign $^{Country)}{
m FL}$ 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral 1 □ M 2X F Days 267-32-4233 MO6 / 0 27 192 Director Usual Residence of Decedent 23a or 28a-f shov 10c. City, Town or Location
Annapolis 10a. State 10b. County 10d. Inside City Limits with the Maryland Examiner must be notified at Director MD Anne Arundel 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21401 1909 Sleepy Hollow Lane permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natural", or itemany injury or other trainmatic. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Yes 2 1 No Black, White, etc. ģ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. 3 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) Jefferson Benjamin Thompson 18. Mother's Name (First, Middle, Maiden Surname)
Maude Leoma Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1081 Crestview Drive Annapolis MD 21409 John J. Donaldson Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hillcrest Mem 03/14/201 Annapolis MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySimplicity Crem & Fun Serv ThomasAllen PA 7090 Ridge Rd Hanover MD Funeral Service License 21. Signature nome 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart disease or condition resulting in death) Lears Medical Due to (or as a conse unce of Examiner Due to (or as a consequible of): Kars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner and I-transit Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year the 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hemory hage 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performed? Yes 2 No fibrillation Atrial this certificate 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Son s examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 1 Nursing Home 4 \(\subseteq \text{Nursing Home} \) 1 Other (Specify) Residence 2 No Hospital 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 IDOA vithin 24 hours after occur.

To the Funeral Director: After th Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending M Investigation ☐ Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 2 March 11, 2011 who completed cause of death (Item 23a) (Type, Print) Braverton St. #201 31: Date filed (Month; Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death ARRAH Physician/ OBERT 20 11 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner ALTIMORE SP 6 If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ፟ M 2 □ F Months Days Pennsylvania Director 67-30-9263 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1

Yes 2 □ No Baltimore City MD N/A10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21224 2800 Dillon Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes 2 No Specify: Specify: White 3 Wildowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Education Principle Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Katherine Rook Robert Darrah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 38 East Mill Rd. Maple Shade, NJ 08052 Helene Darrah- Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1
Burial 2
Cremation 3
Removal from State Bayview Crematory 3-14-2011 | Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral S rvice Lica see 22. Name and Address of Facility Kaczorowski Funeral Home, PA Dundalk Avenue Baltimore, 201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one Immediate Cause (Final OWIA Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Filter Inc. rlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of). resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death byt not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NOMA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier . License numbe Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL 0) 81 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Physician/ Month 10:00a M March 12 Μ. Duda Lisa Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre de Grace 8. Date of Birth
(Month, Day, Year)
6. 1925 <u>Citizens Care Center</u> If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. **Funeral** 1 🗆 M 2 🔀 F Yrs Director 85 Germany 212-32-0966 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 🔀 Yes 2 🗌 No Maryland Harford Aberdeen or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 USA 398 Union Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by I 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiens. Inportant: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2XNo Specify: Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker in home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elizabeth Zuelke Anton Friedrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 398 Union St., Aberdeen, MD 21001 Maria Fothergill (friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gardens 3/15/11 Aberdeen, Maryland ^{22. Name and Address of Facility} Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service Licensee 23a. art 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ leno Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death Check only one) examiner Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No I Director: A Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29b. Signature and title of certifie

Registrar

Number 17 Rev 7/2009

State

31 Date filed (Month Day

MAR 16 2011

taure de Grace.

of death (Item 23a) (Type, Print)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 14 Physician/ - 2011 Walter Finn John 5:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk Genesis Eldercare- Heritage Center 8. Date of Birth (Month, Day, Year) May 26, 1930 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Months 1 □**X**M 2 □ F Maryland Director 217-24-3830 80 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director or 28a-f st notified a Maryland Dundalk Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be r Funeral 7801 Peninsula Expressway Apt 101 21222 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, "natural", or ite Armed Forces?
1 X Yes 2 □ No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Steel 10 years ed other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev William R. Finn Mary Dressel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Finn wife 7801 Peninsula Expressway Apt 101, Dundalk, MD 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 18, 1 XBurial 2 Cremation 3 Removal from State Carrison Forest VA Cemetery Owings Mills, MD. 4 Donation 5 Other (Specify) 2011 . Signature of Funeral Service Licensee ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease or complications that caused the certh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran attending physician and Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as nse s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) . pec the g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of death?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has autopsy page 2 Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death | Check only one) Be examiner? Hospital: မ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury atural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined To the Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопрыете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one)

Registrar

32. Registrar's Signature

31. Date filed (Month, Day, Year,

30. Name and address of person who com-

Dundalle MD 21222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 1352 JACQUELINE 201 Medical A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, of Location of Death 4c. County of Death dumbia Howara Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 Months Days Carolina **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No yarylara 10e. S eet and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6551 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ac 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life, DO NOT use retired 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jean arbara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trans ohnso North 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 Burial 2 Cremation 3 Removal from State Snow HI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ HYPERKALEMIA disease or condition resulting in death) Medical Due to or as a consequence of Examiner RENAL DISEASE STAGE Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury bus to for as a consequence on. Exami YPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month 1 Yes 2 9 Unknown 2 No ed by the a 9 Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEART Records, 1 Yes 2 No 3 Probably 4 Onknown HIV 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy perform death? After this certificate 1 ☐ Yes 2 ☐ No rs after deau... ral Director. After this ce.... **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2NO No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) whe MD DOOS3150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE

Registrar

State

SHAWNMAC

31. Date filed (Month, Day, Year) MAR 1 6 2011

9650 SANTIAGO ROAD

21045

GUPTA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O3 3 Day 12:30 MA GILMORE 2011 LYNETTE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUIMORE MARLAU Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 0-12-62 1 🗆 M 2 🔀 F Hours 48 Yrs **Director** Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director MD BALTIMORE 1 XYes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number ò "natural", or items 23a o edical Examiner must be Funeral 21212 USA MARLAU DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No by 1 Never Married 2 Married 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify Specify: BLACK 3 Divorced Completed and Mental Hygiene.
is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 lepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event, the Medonce. HEALTHCARE Elementary/Seconday (0-12) College (1-4 or 5+) ASSISTANT MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Richard GAINEY BARBARA KELLEK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) BARBARA GAINEY (MOTHER) MARLAU DRIVE. BALTO, MD. 21212 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/19/11 BALTIMORE, MD Devio RIDGE 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCKS 21. Signature of Funeral S 1905 YORK ROAD. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the himal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2. No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: ၉ 1 Tes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After or Attending work? 1 Natural injury 5 Pending death. Accident Investigation 24 hours after deal Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 1 🔆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 020396 15/11 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Davis Hann, MD 3333 N. Calvert St. Ste 107 Baltimore, MD 31. Date filed (Month, Day, Year) State Registrar 16

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		rtment of Health and tificate of Death		giene Reg. No.		08241
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last NETTLE	HUNTLEY			2. Date of De- Month	Day 12	Year 2011	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give Harbor Hospi	fal		4b. City, Town, or Location of De Baltinore			inty of Death	4
*C	Funeral Director		212-31-0001	Sex 7. Age (In yrs. In	79 Yrs.	Months Days Hours N	Ain. 8. Date of Bin (Month, Da	2 Year 1932	9. Birthpla	ace (State or Foreign fry) The Caroline
	Maryland r-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N	/A 10c. City	, Town or Lo	Battim	iore		10	0d. Inside City Limits 1 ☐ res 2 ☐ No
	with the	al Director	10e. Street and Number 903 Bethure	Rd.		10f. Zip Code 21224	5	10g. Citizen	of What Count	ry?
036	be fled within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin' f Yes, specify Cuban, Mexican, P I □ Yes 2□ No Specify:	? (Specify Yes or No uerto Rican, etc.)	E	Race - America Black, White, e ecify: Blace	
21215-0036	i within 72 ho jiene. r than "natur the Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	tent's Usual Occupation kind of work done during most of DO NOT use retired) Laundry Wor	working Ker	16b. Kind o	Privat	ustry
and.	be be eve	To Be C	17. Father's Name (First, Middle, Last Gaston Lea	'K		18. Mother's Rel	Name (First, Middle lie Lea	, Maiden Suri	name)	
, Maryland	ulth a 27 is rtrau	٦	19a. Informant's Name/Relationship (Carol Dukes -	Type Print) -daughter	19b. Mailir 644	ng Address (Street and Number of	or Rural Route Numb	er, City or To Bum	wn, State, Zip	code) 21060 aylad
altimore,	Pages ment of ant: If i		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	emetery, crei Md	sition (Name of natory or other place)	3/19/11	Bath	on - City or To	wn, State Maryla-d
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Ace	in Parker	1 3	2. Name and Address of Facility 572 Frederick	Ave. B	altim	ore, Ma	lryland
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that caused the death one cause on each line. a. Due to (or as a consequ		er the mode of dying, such as ca	rdiac or respiratory a	rrest,		A roximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a nonsequ	1	Metastatic En	dometrial	2 Can	ncar	1 year
,09/	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	I Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	uence of):					
c 687	ertificate I ing physi e as the b	Medical	IF FEMALE:	_d						
.O. Box	he death certific the attending p thed for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	□Ectopic pregnancy □ Other (specify)		I. Date of delive Month	ery Day Year		
rds, P.	quires that the der n signed by the a and be detached for	by	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause given in Part I.		tobacco use o		he cause of death? bably 4 Junknown
Records,	The law requir ate has been si page 2 should	Completed					24a. Was auto perl 1 Yes	s an 2 opsy formed? 2 No	prior to con death?	opsy findings available impletion of cause of
Vital	hysician: The la nis certificate has I director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	Other:	f Death <i>(Check only</i> ing Home 5 ☐ Res		Other (Specil	fv)
n or	Attending Physician: r death. ector After this certifics by the funeral director, p	ion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		28d. Describe			<i>77</i>
Division or	aior Attending Ph affer death. I Director After th diby the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not to determine to	De 28e Place of injury - At ho	ome, farm, st		28f. Location	(Street and Nown, State)	lumber or Rura	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled	Medical C	(Check only 2 Medical Exa	aminer: On the basis of examina	wledge, dea ation and/or i	th occurred at the time, date and exestigation, in my opinion, death	place, and due to the occurred at the time	e cause(s) an	nd manner as s lace, and due t	stated. to the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier	mi Saadi,	MD	29c. License number	٨		signed (Month,	

State Registrar

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)
ABDULGHAN | SARDI 300 | SOUTH HANOVER St. Bultimore, MD, 21225

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 12, Day 2011 Year Physician/ 8:00 A M Hilda Virginia Hackett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 2120 Forestside Drive Aberdeen If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Feb. 9, 1913 Maryland **Director** 98 213**-**28-2426 Usual Residence of Decedent 28a-f show 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State Director 1 🗆 Yes 2 🛣 No Maryland | Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21001 2120 Forestside Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 ANo Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Meat Wrapper 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth A. Fryfogle Milton Calvert Tegeler permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2120 Forestside Dr., Aberdeen, Maryland 21001 19a. Informant's Name/Relationship (Type, Print) Elizabeth A. Schaper / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gdn 3-16-11 Aberdeen, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licen 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 🙏 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): ailure Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2: autopsv performed? Yes 2 No death? 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No Hospital ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature

State Registrar

DHMH 17 Rev 7/2009

1 Com

Name and address of person who completed cause of death (Item 23a) (Type, Print)

HURWITZ, SARALEE

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		State of Maryland / Department of Health and Mental Hygiens										08244					
		1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death											To The County				
	Physicia Medic		SARALEE		e, Last)	HURW	ITZ						2, Date of D	b Da	19h 2	ear Ol	3. Time of Death
C.	Examin	er	4a. Facility Name (if	nor institution	n, give stre	et and number	Bal	time	4b. Ci	ty, Town, or Bal	Location	of Death	re,	40	N/A	Death	
	Funeral Director											Birth Cour	place (State or Foreign htry) NY				
	land show dat		Usual Residence of 10a. State	Decedent 10b. County	,		100 0	ty, Town or	Logation							\exists	10d. Inside City Limits
	arylan a-f sh fied a	Funeral Director	MD		TIMOE	T C		ALTIM									1 Yes 2 No
	or 28 e noti	Dir	10e. Street and Nur		111101	(E	Ъ.	ALITI		Zip Code				10g. C	itizen of Wha	at Cou	ntry?
	s 23a	era	3409 T	ERRAPI	N ROA	VD				212	.08				USA		
	death ritem ner m	Fur	11. Marital Status			Was Deceden	5?	S. 1	3. Was Dec	edent of H	ispanic C ın, Mexic	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black,		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	0 Ft 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			1 Yes 2 If Yes, Give Year or Dates			1 🗆 Yes	2 🛛 No	Specif	iy:			Specify:		WHITE
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Maryland	e filed ntal Hy ed otf even	To Be	17. Father's Name (First, Middle,	Last)	100							e (First, Middle	e, Maiden	Surname)		DETROG
Ž	should be file and Mental I is marked o raumatic eve		SAMUEL 19a, Informant's No	me/Relations	hin (Type	JED Print)		10h M	ailina Addr	an (Strant		NNIE	al Route Numb	or City o	r Town Stat		PEIROS
	12 shoalth an 27 is r trau					AUGHTE	R	1	•				Γ 202,				
ore,	1 and of Hea fitem		20a. Method of Dis	position			20b. l	Place of Dis	sposition (/\	lame of	1		Date	_	ocation - Ci		
Baltimore,	Page ment tant: It		1 Donation			moval from Sta	iic	AAREI				03/	13/2011	. B	ALTIM	ORE	, MD
Ball	permit. Page 1 and 2 sk Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Nu	neral Service	License	2				and Addres							., INC.
			23a. Part 1. Enter	the disease, o	r complica	tions that caus	sed the dear	th. Do not e					ROAD,		12 A T L L	е,	MD 21208 Approximate
	nysician/		Immediate Cause	(Final	only one o	aus, on each l	line.	Kal	Ph	ai C	(Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	ОΠ	C a.	Due to (or a	is a conseq	uence of):		000	26.6	ont	i - (7010	0.0	1	6 months
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	rted J unsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury														
	executed an and rial-transi	EX	that initiated event resulting in death)		C.	Due to (or a	is a conseq	uence of):								\top	
9	ate be	dice			d.											+	
68760	certific nding parties as	N/M	IF FEMALE: 23b. Was decedent	pregnant	230	. If <u>ye</u> s, outcon									23d. Date	of deli	/erv
Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	in the past 12 mooths? 1							Month				Day Year			
P.O.	that the	y Ph	Part II. Other signit	ficant conditi	ons contri	buting to death	h but not re	sulting in th	e underlyir	ıg cause giv	ven in Pa	t I.	23e. Did	tobacco	use contribu	ite to 1	the cause of death?
ds,	quires an signal	ed b											1 □	Yes 2	X No 3	☐ Pro	obably 4 🗆 Unknown
Records,	aw rec las bee	nplet												opsy	pric	or to co	opsy findings available ompletion of cause of
Re	: The I	Con											1 🗆 Yes	formed?		th? Yes	2 🗆 No
ita	sician certifi rector	To Be	25. Was case referr examiner? 1 ☐ Yes 2	ed to medical ≰No	Hos	pital:		1		Oth	er.		k only one)				
of Vital	g Physer this eral di	e: T	27. Manner of Deat			28a. Date of in	atient 2 🗆	28b. Time	of	28c. Injur	4 <u> </u>		ome 5 Res 28d. Describe			Specif	<u>5) </u>
on	ending sath. or: Afte he fun	ficat	1 Natural 2 Accident		igation	(IVIONTI), L	Day, Year)	injur	M	work 1 🗆	? Yes 2	□No					
Division	I or Atter de Directo	Medical Certificate:	3 Suicide 4 Homicide	6 Could determ		28e. Place of I building,	Injury - At he etc. (Specif	ome, farm,	street, fact	ory, office				(Street ar own, State		r Rura	al Route Number,
_	To the Hospital within 24 hours a To the Funeral C completed filled	dical	29a. Certifier 1 (Check 2	Sertifyin Medical	g Physicia Examiner	n: To the best On the basis o	of my know	/ledge, dea on and/or inv	th occured	at the time	, date an	d place, ar occurred a	nd due to the o	ause(s) a	ind manner a	s stat	ed. ause(s) and manner stated.
	the lithin 2 the lomplet	Me				ractioner: To the	he best of m	ny knowledg		curred at th		te and plac	ce, and due to		(s) and mann ate signed (A		
	F≶Fő		* *	XC	ot	al	`			DO	70	317		31	111	11	, ,
	3 1		30. Name and addr	ess of person	who com	oleted cause of	f death (Iter	n 23a) (Type	e, Print)	0-	1.6	2100	الماري	h ((5)	P	cultimere
			and	YK	9	an 1	MD	12	+5+	Ka	<u>01 t</u>	ICC	K,4	41	W	L	ND 2120
	Stat Registra		31. Date filed (Mont	1 G 20'	11	32. Regis	strar's Signa	ture	1				•				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death DAISY JONES Year Physician/ Day A MAR Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ST. THOMAS MORE NURSING PRINCE GEORGE'S HOME HYATTSVILLE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Months Month, Day, 1 🗆 M 2 🔀 F Days SOUTH CAROLINA 1933 68-9653 Director sidence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director MD PRINCE GEORGE'S SPRINGDALE 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9322 HOBART ST 20774 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 3 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Decedent's Usual Occasional Medical (Give kind of work done during most of work life. DO NOT use retired)

DOMESTIC 16b. Kind of Business Industry (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) 12th College (1-4 or 5+) DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JAMES E. PRESTON MARTHA PRESTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARL JONES /SON 9322 HOBART STREET SPRINGDALE, MD. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 3/14/2011 CLINTON, MD. 4 Donation 5 Other (Specify) CAPITOL 21. Sig sture of Funeral Service License 22. Name and Address of Facility 1425 MARYLAND AVE., NE WASHINGTON, WITZ D.C. 20002 or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease. Approximate shock, or heart failure Lis only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition trerios denot Physician/ easis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death the g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in rriy opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 2011 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar 31. Date filed-(Month, Day, Year)

16

DHMH 17 Rev 7/2009

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 11 Physician/ Day 2011 4:45A M ANN JULIA KELLY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death COLLEGE VIEW CARE CENTER-GENESIS Frederick County Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 2**X**XF Months Hours 05/20/2072090 Kentucky 217-34-7835 100 Director Usual Residence of Decedent 28a-f show 10b. County other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 700 Toll House Avenue 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X Xo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. ٥, þ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes XX No Specify: Specify: "natural", Completed 3XXWidowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည eponid be James W. Smith Delilah Harlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Howard E. Kelly 5910 Hummingbird Court, Titusville, Florida 32780 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 5 1 XX Burial 2 Cremation 3 Removal from State orraine Park Cemetery 03/17/2011|Baltimore, Maryland. Donation 5 Other (Specify) 22. Name and Address of Faranti to the ll-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complicate as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Dementing disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): death certificate be executed that initiated events physician are the burial-tr resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) Day detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes 21 Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1100 မ 1 🗋 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury work?
1 Yes 5 Pending 2 🖵 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 060417 MD 3-11-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson Drive, Frederick, MD 21702 Hemen Shah, MD, 65 C 31. Date filed (Month, Day, Year) State barker

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 08247

	Registrar	ate of Death	Reg. No.	, , , , , , , , , , , , , , , , , , , ,
Physician/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death 1350 hrs
Medical Examine	James Allan Keeter 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	February 13, 2011	
	Doctor's Hospital	Lanham	Prince Ge	eorge's
Funeral Director	5. Social Security Number 212-06-4566 6. Sex 7. Age (In yrs. last bit 41	rthday) If Under 1 Year If Under 24H Months Days Hours Mi		Birthplace (State or Foreign Country) Maryland
th the Maryland 23a or 28a-f show any notified at once. al Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georges 10c. City, Town Seal 10c. Street and Number	10f. Zip Code	10g. Citizen of Wha	10d. Inside City Limits 1 X Yes 2 No
th the North the		20706		S.A.
fter death wi	3 Vildowed 4 Divorced in res, diverteal or Dates:	13. Was Decedent of Hispanic Origin? (\(\) If Yes, specify Cuban, Mexican, Puerl \(\) \(\) Yes 2 \(\) No specify: Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	o Ricán, etc.) White, Specify: W work done 16b. Kind of Busi	Mhite
2 3 3 6	Elementary/Secondary (0-12) College (1-4 or 5+)	Construction		
21215-0036 uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical. To Be Complet	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	mployed
21 De fi ent,	Gerald A. Keeter	Karen C	ross	
D 21 should and Me 7 is ma latic ev	19a. Informant's Name/Relationship (Type, Print) [Karen Dennin (Mother)]	9b. Mailing Address (Street and Number or 6606 100th Ave. Sea	· · · · ·	State, Zip Code)
Baltimore, MD 2 semit. Pages I and 2 shou Department of Health and N important: If item 27 is n injury or other traumatic	20a Method of Disposition 20h Place	of Disposition (Name of cemetery,	-	City or Town, State
Baltimo permit. Page Department of Important: injury or oth	21. Signature of Funeral Service Licens	22. Name and Address of Facility R 9013 Annapolis Rd		
Physician /Medical	23a Part I. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or hear	t Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Amitriptyline Intoxication Due to (or as a consequence of):			Deau
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
scuted and transit al Examiner				
e execute cian and riial - trai	UNPENDED AMENDED			1
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Eiledical Certification: To Be Completed by Physician/Medical Eiledical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of leath 0 Unknown	2 Fetal death 3 Ectopic pregress Other (Specify)	23d. Date of d nancy Month	elivery Year
P.O. Es that the digned by the detached by Phy		ng in the underlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death? Probably 4 Unknown
ords, P.C w requires that as been signed to should be deta	J, 			ere autopsy findings available
tal Records, I tian: The law requires certificate has been sig ector, page 2 should be 3e Completed			autopsy priperformed? de 1 ✓ Yes 2 No 1	or to completion of cause of eath? Yes 2 No
Vital hysicians this certil director	examiner? Hospital:	26.Place of Death (Chec Outpatient 3 DOA Other 1 Nurs		Other:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be deace this perification: To Be Completed by Fortification:	1 Ves 2 No In Injection 2 Ver Except 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Pending Investigation	Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred Unknown	d
Division of spiral or Attending hours after death. neral Director: After filled in by the funer Certification:	3 Suicide 6 ✓ Could not be determined (Specify) unknown	farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State) 6606 100th Avenue, Lanham,	
To the Hos within 24 h To the Fur completely		eath occurred at the time, date and place, ar investigation, in my opinion, death occurred	nd due to the cause(s) and manner a lat the time, date and place, and du	as stated. e to the cause(s)
Ne se	29b, Signature and title of certifier	29c. License number O. C.M.E.	29d. Date signer February 14	(Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 1	l1 Penn Street, Baltimore, MD 21	201	
State Registra	31. Date filed (Month, Day, Year) MAR 1 6 2011 32. Registrar's Signature	harles	OCME	
DHMH 17 Rev 1/2001		RIGINAL	VVINE	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Month Year 10:30 A M **Physician** 15, ohn Kirsc 2011 March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Anne Arundel Pasadena 3537 Brickwall Lane Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 12 M 2 □ F Sept 16 1942 Yrs. Maryland 68 Director 215-40-7665 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitors must be notified at 1 ☐Yes 2 KINO Anne Arundel Pasadena Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21122 3537 Brickwall Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) **UPS** Elementary/Secondary (0-12) College (1-4or 5+) Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Katherine Stickels Kirschke ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3537 Brickwall Lane, Pasadena, Maryland 21122 (Wife) Mary Kirschke 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disnosition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Glen Burnie, Maryland 03/15/2011 Atlantic Cremation 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility} McCully-Polyniak Funeral Home 3204 Mountain Road, Pasadena, 21. Signature of Funeral Service Licenses P.A. Maryland 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer months **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physiclan; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 Dres 2 No 3 Probably 4 Unknown certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 □No 1 □Yes 2 L To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day, Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, 05F tol

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20<u>11</u> March 12, Physician/ 12:45 PM William David Kebschull Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Timonium Stella Maris Hospice 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours Min. 1 X M 2 D F Month Bay, Year) 42 Tennessee May Director 415-68-6409 68 Usual Residence of Decedent 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10b. County the Maryland Director 1 ☐ Yes 2 🕇 No Maryland | Harford Churchville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 21028 216 Goucher Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Black, White, etc Yes 2 X No Completed by 1 Never Married 2 Married lid be filed within 72 hours after Mental Hygiene. Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea gines. Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Virginia (nmn) Gourley William George Kebschull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 216 Goucher Way, Churchville, Maryland 21028 Nancy Kebschull / Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Date cemetery, crematory or other place) 1 ★ Burial 2 Cremation 3 ★ Removal from State 4 Donation 5 Other (Specify) Manteo Cemetery 3-17-11 Manteo, NC McComas Funeral Home, F.A. 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee 1317 Cokesbury Road, Abingdon, Maryland 21009 ath (eer) antivax Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Onset and Death Immediate Cause (Final Physician COLON CANCER disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to himoclate cause. Enter Underlying Cause (Disease or linjury Directo (or as a consequence of) within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 No Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X death? 2 No 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify) 2 X No HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

KEBSCHULL

WILLIAM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ 11:10 AM Craig Edward Kupp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** National Institute of Health Be thesda Mintgomer If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1**X**M 2 □ F Days Hours (Month Day Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 9016 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married Ş 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: 3 - Widowed 4 - Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) writex Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 2 50 19a. Informant's Name/Relationship (Type, PyInt) 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) reenu 21. Signatural Service License 22. Name and Address of Famility Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acuterenal failure Physician/ days disease or condition Medical resulting in death) Due to (or as a consequence of): 10 WEEKS Examiner tamponade ericardial effusion and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Ulia to (or as a consequence of): year metastatic mesotheliona cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an performed? 1 ☐ Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, and the funeral director. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 2 ☐ Accider
3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03/11/2011 25 6907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) National Cancer Institute, 9000 Rockville Pile. MD 20892 Lindy Davis 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert E. Lacher Sr. 0353 March 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) Funeral Davs Hours Min. OCL . 5. Country) 219-22-5516 **№**□ M 2 □ F 83 Director MD Usual Residence of Decedent 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director Baltimore Essex 1 Yes 2 V No 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 21221 USA 412 S. Taylor Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Progress Brass Elementary/Seconday (0-12) College (1-4 or 5+) Engraver 11th Die Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Ward Albert Lacher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean W. Lacher /wife 412 S. Taylor Avenue Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery, crematory or other place)
Oak Lawn Cemetery 3/15/11 1 Burial 2 Cremation 3 Removal from State Baltimore MD 4 Donation Other (Specify) 22. Name and Address of Facility 21. Signature of yur rai Service Licensee 300 Mace Ave. Connelly Funeral Home of Essex 21221 oli 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Sonset and Death Immediate Cause (Final Myocardia Physician disease or condition resulting in death) Medical Examiner oronary Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Aortic Valve Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death 1 Yes 2 Q the a g 🗌 Unknown detached as been signed by the 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed Yes 2 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signe

State Registrar

32. Registrar s Signa

State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** March 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** 1071971925 145-16-5543 85 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 √ No Director MERCER N.I LAWRENCEVILLE 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 08648 15 RENEE COURT USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces
1 Ares 2 If Yes, Give
Year or Dates: Late 2 1215-0036

Department of Health and Mental Hygiene.
Important: If item 27 is marked other any Injury or other. Black White etc. 1 Never Married 2 X Married 2 🗌 No WHITE 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) APPLIANCE Elementary/Secondary (0-12) 12 College (1-4 or 5+) OWNER / OPERATOR REPAIR SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MORRIS LASKEY ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) FRANCES LASKEY / WIFE 15 RENEE COURT LAWRENCEVILLE, NJ 08648 20b. Place of Disposition (Name of cemetery, crematory or other place)
WORKERS OF TRUTH CEM. 3/13/2011 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Xemoval from State HAMILTON, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. nso 8900 REISTERSTOWN ROAD PIKESVILLE, MD rt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events attending physician and I for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Tetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ director, page 2 should be 2 No 1 Tes 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 2**X** No 1 Tes Yes this certificate al or Attending Physician: T safter death.

I Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 4 Nursing Home 2 ER/Outpatient 3 🗆 DOA 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident (Month, Day Year) Pending investigation 1 Yes 2 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 1 24 hours a Hospital 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margaret Hayes Ma 600 North Wolfe St, Baltimore, MD, 21287 MI

Registrar

State

31. Date filed Month, Day, Year)

MAR 1 6 2011

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Month Day Pregnant at time of death Yes 2 No signed by the a 9 \ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? After this certificate Yes 2 No 1 ☐ Yes 2 🔀 No completed filled in by the funeral director, Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 Tes 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23p) (Type, Print) HOF Cini SILVIEW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Amend Item 1 per dr., g913,03/16/2011dhb Certificate of Death Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) Geraldine 2. Date of Death 3. Time of Death Loran Month Day Year Physician/ 5:56 P M THE WILLIAM C MARCH 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6701 PARKWAY ROAD **TDLEWYLDE** BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Min Months Days Hours 1 □ M 2 🔽 F 1 29729 P1 9979 91 **Director** 116-07-6267 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at Director 1 Yes 2 No MD BALTIMORE IDLEWYLDE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21239 USA 6701 PARKWAY ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces

1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: WHITE 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ SIDNEY LIPSIG SILVERS HELEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6701 PARKWAY ROAD IDLEWYLDE, MD JORDAN LORAN / SON injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM 3/14/2011 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. J. Maria 60 PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition H Medical resulting in death) Due to (or as a consequence of) Examiner DISHASIS Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) Yes 9 Unknown signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1.24 hours after death.

e Funeral Director; After this certificate has le Funeral director, page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🖳 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN 9109 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 14. Day 2011 Year 7:50A MARGOLIS AL ICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore None 6211 Pinehurst Road . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XXF Months Days Hours Min 165-24-8721 05%0694930 80 Pennsylvania Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d Inside City Limits be filed within 72 hours after death with the Maryland items 23a or 28a-f shoner must be notified at Director Maryland None Baltimore 1 XXVes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6211 Pinehurst Road 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 X Married Completed by 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Administrator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Kahl Alice Gertrude Raab 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra HUS. 6211 Pinehurst Road Baltimore, Maryland 21212 Simeon Gerold Margolis 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

GreenMount Crematory 03/17/2011 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) onature of Funeral Sa 22. Name and Address of Monty Chell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryalnd 21212 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BREAST METASTATIC disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes Be 25. Was case referred to modical examiner? 26. Place of Death (Check only one) Hospital 2 14 No ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director, After 1 ANatural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Fractional. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 15 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Spyridon Marinopoulos MD 401 North Caroline Street Baltimore, Maryland 21231 31. Date filed (Month, Day Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#9.11, per INF. G924, 2/16/2012, WS
State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:17 PM WILLIAM, MOORE 03 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City. Town, or Location of Death BALTIMORE SHOCK TRAUMA BALTIMORE NΑ 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours Min. North Carolina 214-38-7844 69 10-05-41 **Director** Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director Baltimore NA 28a-f MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral USA 2700 N. Charles Street 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces?

1 Yes 2 No 1 X Never Married 2 Married ō Completed by 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: American 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fork Lift Operator 12th Grade Maple Press Co. NA Be traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked o မ Joseph Moore Carrie Bonner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Janine Moore-Sister 2524 Terra Firma Road Baltimore, MD 21225 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of Department of Important: If it any injury or o cemetery, crematory or other place)
Metro Crematory 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 03-16-11 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SEPSIS, SEVERE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 1-2 WEEKS STAPHYLOCOCCUS ABREUS BACTEREMIA Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury 1-Z WEEKS Hospital or Attending Physician: The law requires that the death certificate be executed ENDOCARDITIS that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END-STAGE RENAL DISEASE. UBART FAILURE Division of Vital Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo Other: |@ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) NEBRASKA 12011 23535 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEAN REILLY, MA University of Maryland 22 S. Greene Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

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Certificate of Death

Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201 Physician/ Month ()3 01:33 A M Medved elizaveta Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** University of Maryland Medical Center Baltimore N/A If Under 1 Year If Under 24 Hrs.

Pays Hours Min. 8. Date of Birth Birthplace (State or Foreign Country)
 DIVICET A 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 🗌 M 2 🗓 F 1/20/2 Pay 1/952 RUSSIA 214-43-9859 58 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tyes 2 X No BALTIMORE REISTERSTOWN MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 102 MARDAN DRIVE 21136 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: WHITE If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** TEACHER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ **BARSHAB** GORNOPLSKIY RUHALE RUHOLE ABRIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 MARDAN DRIVE, REISTERSTOWN, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM 03/14/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner days Bacteremia Sequentially list conditions, if any, leading to immediate causes. Enter Uncerlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician the burial Physician/Medical P.O. Box 68760 ding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Preumonia 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Endocarditis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy End stage renal disease 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral iniury 1 Natural 5 Pending Investigation ☐ Accident 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe March 11, 2011 P2554 atherine ochrenk MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St. Baltimore, MD 21201 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 40303 Halt Calherine ROPP Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Good Samaritan Nursing Home Baltimore n/a 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye July 29 9. Birthplace (State or Foreign 1 🗆 M 2 🗔 Months Hours Year. Country) Director 228-30-2284 90 July VA Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore n/a X□ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral hours after death with 1651 E. Belvedere Ave. 21239 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Black, White, etc. þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3℃ Widowed 4 □ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Je filed with... *al Hygiene. *r than "r 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Private Homes Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of ည Charlie Parker Annie Hawks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Celia Willis (daughter) 751 Saratoga St.Apt.424 Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cem. 4 Donation 5 Other (Specify) March22, 20Ball to, Md. Range of Funeral Service Licensee 22. Name and Address of Facility alvin B. Scruggs Funeral Home 141 Preston E St Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on ea Interval Between Onset and Death Immediate Cause (Final Prysician/ pones disease or condition resulting in death) Medical less their Examiner TWI CERECK) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ō Month Pregnant at time of death 5 Other (specify) Dav Year the detached 9 Unknown 9 Unknown P.O. Ś been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy certificate performed 1 🗌 Yes 2 No Yes 21 No in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury Investigation Accident 1 ☐ Yes 2 ☐ No 2'☐ Accider 3 ☐ Suicide 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie th, Day, Year) 29d. Date signed (Month, 3066 March 15 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:40 AM Allvn. McOuav 2011 Medical March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 401 Cherry Oak Court Taneytown Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min 1 M 2 X F 09/29/1960 Country) Maryland Hours Director 213-78-9938 Yrs. Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Carroll Taneytown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 401 Cherry Oak Court U.S.A. 21787 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Force Black, White, etc. 0 þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 DWidowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Heath and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Masonry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Winkles Taylor Janice Kay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany McQuay / Daughter 401 Cherry Oak Court, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anatony Gifts Registry 03/15/2011 Hanover, Maryland 21. Signature of Fune al Service Licenses 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Dav Pregnant at time of death 9 🗌 Unknown 9 Unknown been signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Funeral Director; After this certificate has been signs completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 -10 Yes 2 N 1 Yes Be 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) itle of certifier 29b. Signature ar 29d. Date signed (Month, Dav. Year) ess of person who complet ed cause of death (Item 23a) (Type, Print) Flavio Kruter MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 1:45PM 03 Russell Meyer, Sr. Lawrence Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Anne Arundel 1110 Marley Creek Drive <u>Glen Burnie</u> 8. Date of Birth (Month, Day, Year) 05/30/1955 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) ar If Under 24 Hrs **Funeral** Min. Months Hours 1 X M 2 - F 55 Director 218-62-9864 Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 X No Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A 21060 1110 Marley Creek Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced ear or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. the Housing Maintenance Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bel1 Elmira Margaret John Joseph Meyer Page 1 and 2 should permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hanover, PA 17331 /Son 3005 Grandview Road Lawrence R. Meyer, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/21/2011 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility 1 2nd Avenue SW Signature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause un each line Immediate Cause (Final ysician/ uranima disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undershing Cause (Disease or linjury Examine Due to (or as a consequence of): and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b, Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown ed by the detached ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Minknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death,

To the Funeral Director: After this certificate I
completed filled in by the funeral director, page 1 🔲 Yes 2 XNo ☐ Yes 2 🔀 Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital 2 XNo 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No iniury 1 🔀 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certific 29c. License number 38958 n who completed cause of death (Item 23a) (Type, Print) Highway SW Clan Burne MO21061 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 12, Day 2011 ear Cyrus Donald Moyer, Sr. 11:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Havre de Grace 1207 Bern Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day Mov. 19) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1926 1 XM 2 □ F Pennsylvania Director 211-18-9563 84 Usual Residence of Decedent or 28a-f show the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No Havre de Grace Maryland Harford 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 1207 Bern Drive 21078 filed within 72 hours after death al Hygiene. **d other than "natural", or items** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. þ 1 XYes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Packaging Specialist U.S. Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Paul M. Moyer Verna (unk) Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheryl L. Spooner / Daughter 1207 Bern Drive, Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Ignatius Cath. Cem. 3-17-11 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) fur of Funeral & rvice Licer Signatur 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final yıysician, disease or condition resulting in death) Medical Due to (or as a c (s uence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Uncertying Cause or iinjury Due to (or as a consequence of): nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death

1 Vatural
2 Accident within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year one D66912 March 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 S. Atwood Road, Bel Air, MD 21014 Venkata Parsa 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:45 A M March leane He 1105 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE SEASONS HOSPICE @ 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 0372971918 MD 92 Director 217**-**07-7788 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 XNo BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number Funeral 21208 USA 7 SLADE AVENUE, #521 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 should be filed within 72 hours after WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 ₩Widowed 4 □ Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) the OWN HOME HOMEMAKER other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental မ UNKNOWN DAVIS BESSIE TSAAC and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2025 JOLLY ROAD, BALTIMORE, MD Health tem 27 Page 1 and 2 GLENN MILLER/SON 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of 0 ∓ i cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or BETH EL MEMORIAL PK | 03/14/2011 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Hemorrhage disease or condition resulting in death) Intracrania Medical Due to (or as a consequence of) Examiner our Jensich Sequentially list conditions, Due to as a consequence of cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Euhours after death.

Funeral Director: After this certificate has been signed by the attending physicis the filled in by the funeral director, page 2 should be detached for use as the burn but the funeral director, page 2 should be detached for use as the burn. P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 T 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and the 29c. License numbe 29d. Date signed (Month, Day, Year) March 12 2011 30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print) 2835 Avenue Baltonie Mazizac

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2011

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23d, 26 per dr., g913, 03/16/2011 dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nagel Day Faina MARCH 09 11:15 PM 201 Ĭ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12313 POINT FIELD DRIVE HOWARD FULTON Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
BELARUS **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🗓 F Davs Hours Min 04701/1956 Director 214-13-2636 54 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2x√x No MD HOWARD FULTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12313 POINT FIELD DRIVE 20759 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ð 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify: Completed WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) DENTIST DENTISTRY other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be filed f Health and Mental H item 27 is marked of 2 ALEKSANDER OKUN SARA SHENDEROVICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS NAGEL/HUSBAND 12313 POINT FIELD DRIVE, FULTON, MD 20759 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GDNS 03/13/2011 OLNEY, MD Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Metasta h sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): months Examiner e ittly on tell yllettrough Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ြု 2 🕅 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after deau.
the Funeral Director: After this inpleted filled in by the funeral di 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 0 46 855 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3.10.11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Portnerst Porkway Mayland Columbia Silveman 910 10 Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vauiasku 2:APM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Coeriatric Center evindale. Saltimore Funeral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 1 🛣M 2 🗆 F Hours Director 213-12-0796 91 MD Usual Residence of Decedent Show 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 28a-f MD BALTIMORE 1 Tes 21/2 No BALTIMORE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3800 OLD COURT ROAD, #201A 21208 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 XWidowed 4 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ed other than " th and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRODUCTION PLANNER MARTIN MARIETTA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ of Health and Ments fitem 27 is marked rother traumatic e WILLIAM NAVIASKY **EVA** DAHNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 ROBIN REDDING/DAUGHTER 5508 PLYMOUTH ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State jo <u>F</u> 9 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 03/14/2011 BALTIMORE, MD of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. echou 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Ph. sician/ artinson ica disease or condition resulting in death) moun Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events. Examine Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. Yunknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?/ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: 욘 4 Nursing Home 5 Residence 6 Other (Specify) After this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation after death Director: 3 Suicide 4 Homicide within 24 hours after de To the Funeral Directo completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Le Namouse CRNP 03/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Ele Ha MOSSE 2434 W. Bluddere Ave Baltimore MD 21215 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

11-01988 Video Parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2011 0825

Physician/ 1. Decedent's Name (First, Middle, Last) Medical Examiner Reg. No. 2. Date of Death Month Day March 13, 2011	3. Time of Death
	Year 1025 hrs
4a. Facility Name (if not institution, give street and number) Maryland General Hospital 4b. City, Town, or Location of Death Baltimore	nty of Death
Funeral Director 5. Social Security Numbers 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 94 2 197 Usual Residence of Decedent	9. Birthplace (State or Foreign Country)
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1
The street and Number 10e. Street and Number 10f. Zip Code 10g. Citizen of	What Country? USA
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	ace - American Indian, Black, Inite, etc. fy: Black
Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	Business/Industry
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The plant of the plant of Disposition (Name of cemetery, Date 120c. Location (Name of cemetery), Date 120c. Location (Name of cemetery)	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location of Disposition (Name of cemetery) 20c. Location of Disposition (Name	tomore, and
Julyan C. Jules 15/5/ Balto. Nat I File (2	1229)
Physician //Medical Examiner 23a. Part I. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or large failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or large failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Between Onset and
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.	
events resulting in death) Last d. X UNPENDED AMENDED	
FFEMALE: 23d. Date 23d.	e of delivery n Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conditions of the underlying cause given in Part I. 23e. Did tobacco use conditions of the underlying cause given in Part I. 23e. Did tobacco use conditions of the underlying cause given in Part I. 23e. Did tobacco use conditions of the underlying cause given in Part II.	entribute to the cause of death?
Chronic Alcohol Abuse Chronic Alcohol Abuse	Probably 4 Unknown b. Were autopsy findings available
24a. Was an autopsy performed? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 27. Warsing Home 5 Residence 6	prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6	5 Other:
27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occur (Month, Day,Year) 28d. Describe how injury occur (Month, Day,Year) 28d. Describe how injury occur (Month, Day,Year)	eurred
27. Manner of Death 1	mber or Rural Route Number, City
4 Homicide (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and under the time, date and place, and and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signature.	d due to the cause(s)
29b. Signature and title of certifier 29c. License number O.C.M.E. March 14	igned (Month, Day, Year) 4, 2011
30. Name an address of person who completed cluse of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State State Registrar MAR 1 6 2011 Assistant Medical Examine 111 Ferri Street, Baltimore, MID 21201 Leave B. Baltimore, MID 21201 Leave B. Baltimore, MID 21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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T	Funeral		5. Social Security N	umber 6		Age (In yrs. i	• • •	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir	th	9. Bir	thplace (State or Foreign untry)
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華	permit. Page 1 Department of Important: If is any injury or o		4 X Donation 21. Signature of Fur		11'	Ana	atany Gi					5/2011	Har	nover,	Maryland
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0	Hospital or Attending Physician: The law requires that the death certificate be executed thous after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal			d										
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2	Medical Exa	nysician: To the best miner: On the basis o	f examination	and/or investi	gation, in m	y opinion	, death occ	curred at t	he time, date a	nd place, a	and due to the o	ause(s) and manner stated.
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	10		30. Name and address	ss of person who	completed cause of	death (Item	23a) (Type, P	rint)	Lø	, , , ,	, ,			• /	0 [
	10		STANLE	000	SNILWS	Ki	m	9 32	Cox	Rd,	Hunt	ingtow	n, MI	20639	
	Stat Registra	~	31. Date filed (Month) MAR 1 6	Day, Year)	32. Regis	trar's Signat	ure								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ 08267 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 1:25 P M William Joseph Polischeck March 10 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Abingdon 3714 Goodwill Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5, Social Security Number Funeral Year 1941 Days Mar. 20 Hours Min. 1 ፟ M 2 □ F Months Pennsylvania 69 Director 220-36-4468 Usual Residence of Decedent 10d, Inside City Limits 28a-f show 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 XNo Abingdon Harford Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21009 USA 3714 Goodwill Court 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. fitem 27 is marked other than "natural", or items other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Millwright Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Andrew (nmn) Polischeck Margaret Theresa Toth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 869 Ellicott Drive, Bel Air, Maryland 21015 Margaret A. Polischeck/Daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) permit. Page 1
Department of I
Important: If it
any injury or o ğ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdn.: 3/12/2011 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Lice see 1317 Cokesbury Road, Abingdon, Maryland 21009 antivacci 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line AThEROSLEROTIC Immediate Cause (Final CARDIDVASCULAR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to für as a nonsaurence offi if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 attending pl for use as tl IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No by the a 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 🗌 No 3 🗍 Probably 4 💆 Unknown dements A. Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed? Yes 2 2 N death? 1 Tes 2 No within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \square Nursing Home 5 \bigcirc Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) West d 355 22 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark J. Wild, MD 2 North Ave., Bel Air, Maryland 21014 Mark J. Wild, MD

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar 08268 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jennie Polkowski March 13ay 201 Year 5:45p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Center Dundalk Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 30 9. Birthplace (State or Foreign 1 □ M 2 🖫 F Months Days Min ^{Year)} 1<u>913</u> Hours 219-56-3279 Country) Director 97 MD Usual Residence of Decedent show or 28a-f shove e notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code ms 23a or must be 10a. Citizen of What Country? Funeral 7252 Gough Street 21224 USA ral", or items ? I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 10. Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify 3 Wildowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled 1st Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Polkowski Julia Bedwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Polkowski /nephew 7252 Gough Street Baltimore MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o Department of 1 Burial 2x Cremation 3 Removal from State Bayview Crematory 3/14/11 4 Donation 5 Other (Specify) Baltimore MD Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the deap shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final of Hyoloidile disease or condition resulting in death) Medical CCARDIOVASCULAR Examiner SCLERGT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated exacts. Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to redical Be 26. Place of Deat heck only one) examiner? 1 Tyes 2 **N**o မ Other After this 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manny of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu d title of certific 29c. l ause of death (Item 23a) (Type, Frint) 0

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Kowe March 12:32 A M Brooklyn 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5-22-30 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In vrs. last birthday, **Funeral** 20 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show must be notified at 1 ☐ Yes 2 No Director imore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number þ 21237 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? items ? Race - American Indian. Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married ò 1 ☐ Yes 2 🗹 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other than "natu (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked of traumatic ever 10 ina Jaccus ဂ္ owe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 20/4/more MI) 2/237 20a. Method of Disposition 20b. Place of Disposition (Name of cerhetery, crematory or other p 20c. Location - City or Tewn, State Department of Important: If its any injury or o 3 Removal from State 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility a Vo Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final acute **Physician** respiratory distres Syndrome disease or condition resulting in death) /Medical Examiner broncho - Dulmona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a co sequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician and is the burial-tran resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical stive as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death d by the al 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: 1 Inpatient Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ this 27. Manner of Death 1 Natural in by the funeral 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation s after death. 2 □ No 1 Tes 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) filled i 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D \$\$ 696

Registrar

DHMH 17 Rev 1/2001

State

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

DALLMAN

31. Date filed (Month, Day, Year)

MAR 16 2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS, G913, 3/16/2011, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 13, 2011 Elizabeth Righetti 11:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1015 Hazel Lane Bel Air Harford 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 17, 1 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 □XF Months Country) New Jersev Director 145-09-0424 91 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits New State Director 1 X Yes 2 ☐ No Middlesex East Brunswick Jersey 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ò ms 23a or must be r by Funeral 10 Harvey Circle 08816 USA should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status is marked other than "natural", or ite aumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🖾 No "natural", or 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) And the control of Health and Me.

"ent of Health and Me."

"tem 27 is marked c.

"traumatic ev." ၉ John (nmn) Patrick Elizabeth (nmn) Bovza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Bartol / Daughter 1015 Hazel Lane, Bel Air, Maryland, 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 201 1 Burial 2 Cremation 3 X Removal from State Holy Cross Burial Pk. 3/18/2011 | South Brunswick, NJ 4 ☐ Donation 5 ☐ Other (Specify) Service 22. Name and Address of Facility McComas Funeral Home, P.A. 3 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure, List only one cause on each line MARCH Immediate Cause (Final END Physician/ disease or condition resulting in death) STAG Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 12ABETH IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Kighett Other: 4 In Nursing Home 5 Residence 6 Nother (Specify Residence မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature ap ٥ D0056296 of person who completed cause of death (Item 23a) (Type, Print) Atwood RD. SUITE 206 BIRNDAUM MD. 31. Date filed (Month, Day, Year)

**AR 1 6 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Type of Time in Dia	on machaid min	Ellouio Ali	Johioo Ai o	7.4.
State of Maryland /	Department of H	lealth and Mei	ntal Hygiene	z U

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** 2.10PM Mathilde Klara Ramsey /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Agnes Hospita Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 215-40-7140 83 Director 10/18/1927 Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Sudbury Road 21090 United States or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MD State Department Department of Health and Mental Hyglene. Important: If item 27 Is marked other than any injury or other traumatic event, Inc. Maonee. Elementary/Secondary (0-12) College (1-4or 5+) Accreditation Specialist of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Heinrich Keller Klara Hoffman ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090 500 Sudbury Road Linthicum, Maryland Mr. Timothy H. Ramsey / Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 03/16/2011 | Glen Burnie, MD 4 Donation 5 Dother (Specify) Atlantic Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPURIENSION 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 🔼 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 № 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature, and title, of certifier 29c. License number 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Comsey, Mathilde

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08272 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2ď¶"[10:35 Pm Ronald Joseph Rhoades /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent Chestertown Chestertown Nursing & Rehab If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 □ F 212-40-880 **Director** 5/2/39 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Worton 10g. Citizen of What Country? 10e. Street and Number death with 2500 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola FetterolF Samuel ဂ Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Parters (rove Rd Worton M)

The of ther place)

Date w 20c. Location - City or Town, State Samue Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Albertaun, PA 4 Donation 5 ☐ Other (Specify) 21. Signature 1232 Midvalley Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. App mate Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) **Physician** with metertasis Due to (or as a confequence f): ewmonth /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. ed by the detached if signed by the best of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ O COPD @ HAN 3) TYPE I DM 1 Pres 2 No 3 Probably 4 Unknown Completed @ Bipolar Disorder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page this certificate performed 2 No of Vital 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes 2∐HNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 2 D 21313 Willem, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Ave, Chestertown, MD 21620 KIN K. WUN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 10 2011 9:55 p STEVEN YALE ROSEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 - F 0#12291952 MD 213-64-5603 58 **Director** Usual Residence of Deceden 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ROSEN, STEVEN Baltimore, Maryland 21215-0036 event, the Medical Examiner must be notified 1 Yes 2 No OWINGS MILLS BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21117 124 C HARRY LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No 1 Never Married XX Married "natural", or þ Specify: WHITE If Yes, Give Year or Dates 1 ☐ Yes 2XXX No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's nijury or other traumatic event, the Meany injury or other traumatic event, the Meany ence. life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) HOME IMPROVEMENTS CONTRACTOR 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) COHEN SHIRLEY M. RONALD ROSEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 C HARRY LANE, OWINGS MILLS, MD 21117 RANDI ROSEN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State CARROLL CREMATION, INCD3/14/2011 HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. INTRACEREBRAL EDEMA Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MEMSTASES Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying INKNOWN PRIMARY CANCER To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burnal-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D0060687 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC, 6701 NEHARES ST, BACTIMORE MO THOMAS M 31. Date filed (Month, Day, Year) 32. Registra s Signat MAR 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ MARCH 12 Day **BEVERLY** ROBINSON 2011 Medical 10:40 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death COURTLAND GARDENS BALTIMOREBALTIMORE 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 ☐ M 2🗶 F Days 11/22/1921 Months Hours Director 260-36-0179 89 MDUsual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fine 27 is marked other than "natural" any injury or other trainments. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 Yes 2X No 10e. Street and Number 10f. Zin Code 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 6802 OLD PIMLICO ROAD 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No Specify. Completed 3 XWidowed 4 Divorced Specify. Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER-PSYCHOLOGIST EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MAURICE JOLSON LEVINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY HOFFBERGER/DAUGHTER 3501 ANTON FARMS ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery crematory or other place)
ARLINGTON CHIZUK
AMUNO CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 03/14/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. www 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INFARCTION MYOCHROIAL disease or condition seconds Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ALLHEIMERS DEMENTIH - END STAGE Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h performed death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 1 🗌 Yes ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No. ☐ Accident Investigation filled in by the 3 Suicide 4 Homicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier npleted (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 13,11 030377 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARL HEIGHTS AVE mo PUBLIT M. 6503 BALT MD 21215 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

MAR 16

08275

			State Registrar			Certificate	of Death		Reg. No.			
	Physici	an/	1. Decedent's Name (First, Middle, I	•				2. Date of Death			f Death	
	Medi	cal		osephine	Rybcz			March	ľ¾,	2 01 1	2:40	P . M
	Exami	ner	4a. Facility Name (if not institution, g		-1 C	4b. City,	Town, or Location of D	Death		y of Death		
	Funeral		Upper Chesape 5. Social Security Number 6		al Cer.		el Air 1 Year If Under 24	Uro Lo D		ford		
	Director		217-18-2781 Usual Residence of Decedent	1 □ M 2 🖾 F		Yrs. Months			, 1924	9. Birthr Count Mar	place (State of try) 1 and	r Foreign
	and shov	ē	10a. State 10b. County		10c. City, Tow	n or Location				1	I 0d. Inside Ci	tv Limits
	he Maryland or 28a-f sho	rec	Md.		Ba1	timore	City					2 🗆 No
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	th with ms 23 must	Funeral Director	6731 Boston A	venue		2	1222		U.:	S.A.		
A 10	r dea or iter niner		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		13. Was Decede If Yes, specif	ent of Hispanic Origin y Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Rad	ce - America		
77	hours after death with the Maryland natural", or items 23a or 28a-f sho lical Examiner must be notified at	Completed by	3 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates,	No		☑ No Specify:		Specify		White	
144C	hour natur	Sete	15. Decedent's	Education	16a.	Decedent's Usual	Occupation		16b. Kind of B			
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100 d 212	d with tygler ther t	BeC	8th			Nursery				orist		
anc	be file antal F ced o	10 E	17. Father's Name <i>(First, Middle, Las</i> Joseph Glab	t)				Name (First, Middle	Maiden Surnam	e) (ur	nk)	
	ould I		19a. Informant's Name/Relationship	Type Print Dallo	hted).		Anto	inette				
DOD 3/14/11 TDD 1440 Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be once.		19a. Informant's Name/Relationship Patricia Trom	peter	13	09 Alle	nby Cour	r Rural Route Number t Bel A	ir, City or Town, S ir, Mary	itate, Zip Ci ylanc	1 210	14
0 20	ige 1 and for the form of the		1 Str Burial 2 Cremation 3	☐ Removal from State	20b. Place of cemeter	Disposition (Name y, crematory or oth	of er place) Ma	ır e#	20c. Location	- City or Tov	wn, State	
DOD altimo	nit. Pa artmel ortani injury		4 ☐ Donation 5 ☐ Other (Spe	cify)	St.St	anislau	s Cem 1	.8, 2011	Baltir	nore,	Mary.	land
Ba	Department of the service of the ser		21. Signature of Funeral Service Lice	<u> </u>	ev I	1201 D	Address of Facility a undalk A	venue B	altimon	eral e, N	Home 4d.212	, P. A 222
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that caused one cause on each line.	the death. Do n	ot enter the mode	of dying, such as card	diac or respiratory ar	rest,		Approximate Interval Betw	
D	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	- 2		LONIA	•				Onset and D	
J	Examiner		resulting in death)	Due to (or as a	consequence o	f):						
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ع	uted d ansit	Examiner	Sequentially list conditions, if any, equity to introduce cause. Enter Underlying Cause (Disease or iinjury that initiated events	_		,-						
Genev	exect an an rial-tr		resulting in death) Last	Due to (or as a	consequence o	f):						
0.09	certificate be executed inding physician and use as the burial-transit	/Medical		d								
Ski, (68760	ertifica Jing p		IF FEMALE:	00- 16								
Box	v requires that the death certificate be executed to been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🌠o 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	□ Fetal death	3 Ectopic pre 5 Other (spec	gnancy ify)		23d. Dat Moi	te of deliver		ear
4bc.	hat the ed by detac	된	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying car	use given in Part I.	23e Did to	bacco use contr	ibuto to the	acuse of de	eth?
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3ec	ician: The law certificate has rector, page 2 a	E	HYPER	RIEWSCOA	J			autopperfo	rmed? d	rior to com le <u>at</u> h?	pletion of cau	use of
355 al R	ian: T	Be	25. Was case referred to medical examiner?				26. Place of Death (C		2 No 1	☐ Yes 2	: No	_
£ 500	hysic his ce Il direc	잍	1 Tes 2 Dolo	Hospital: 1 Anpatien	t 2 ER/Out	patient 3 DOA	Othori	g Home 5 Resid	ence 6 Othe	r (Specify)		
50 50	ling P	ate:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	Year) 28b. Tir inj	me of 28c	Injury at		ow injury occurre			
Sio	ottend death stor: / y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not I	20	111	М	work? 1 Yes 2 No					
MECC509635 R_{γ} Division of Vital Records,	al or A s after Direction by		4 L Homicide determined	28e. Place of Injury building, etc. (Specify)	n, street, factory, o	ffice	28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural R	oute Number	r,
2 "	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sig completed filled in by the funeral director, page 2 should be	Medical	29a. Certifier 1 Certifying Phy	rsician: To the best of m	y knowledge, de	eath occured at the	time, date and place	and due to the cau	ise(s) and manne	r as stated		_
	the H		only one) 3 Certifying Nur	niner: On the basis of example of example of the best	mination and/or i	investigation in my	opinion doath accurre	and not the time where as		A - 11	()	ner stated.
	6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2	9b. Signature and title of certifier	0		29c. Li	cense number		29d. Date signed	(Month, Da	ay, Year)	
		-		Dwoles		120 0	08096	/	MARCH			_
D				completed cause of dear	th (Item 23a) (Ty	pe, Print)	SFULPO	RD AM	BEL	-MIR	MOS,	1014
	State Registra		1. Date filed (Month, Day, Year) NAR 1 6 2011	32. Registrar's	Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fh g913 3-16-11 vt
State of Maryland / Department of Health and Mental Hygiene? 08276 Certificate of Death 2. Date of Death 3. Time of Death Month 09:30 PM Smith March 14 2011 4b. City, Town, or Location of Death 4c. County of Death Pasadena Anne Arundel 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Davs Hours Min. Dec. 22 1940 Country) DC 70 10b. County 10d. Inside City Limits 10c. City. Town or Location Anne Arundel Pasadena 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? USA

Black, White, etc.

Recs. & Parks

White

Approximate

Interval Between Onset and Death

Year

Day

24b. Were autopsy findings available prior to completion of cause of

1 Yes 2 No

3 Probably 4 Unknown

Month

death?

No

State Registrar Decedent's Name (First, Middle, Last) Physician/ Eileen Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 30 South Carolina Avenue 5. Social Security Number Funeral **Director** 215-38-5928 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State with the Maryland Director Maryland 10e. Street and Number Funeral 30 South Carolina Avenue 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? à 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County Elementary/Seconday (0-12) College (1-4 or 5+) 12 Office Manager Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bennett Patrick Helen Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Smith (spouse) 30 South Carolina Avenue, Pasadena, MD 21122 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 18 1 Durial 2 Cremation 3 Removal from State 2011 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part .. Enter the disease, or complications that saused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ PMen disease or condition resulting in death) Medical Due to (o onsequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Pregnant at time of death sate has been signed by the a page 2 should be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes Completed 24a. Was an autopsy perform After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 မ 4 Nursing Home 5 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 C Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury 5 Pending Division 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Mol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 500 M Charles Edwin Schreiner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Sept. 02 Country) 220-38-7899 69 1941 **Director** MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 361 Ridge Road 21122 USA items should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc ō Completed by 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: If Yes, Give than "natural" 3 Widowed 4 Divorced Year or Dates traumatic event, the Medica 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Glass Manufacturer 12 and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Charles Schreiner Margaret Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Elsie Marie Schreiner (spouse) 361 Ridge Road, Pasadena, MD 21122 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗀 Cremation 3 🗀 Removal from State 3/22/11 injury 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem rownsville, Maryland Signat of Funeral Service Livens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the ease, or comp Approximate shock, or heart failure. List only on ach line terval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions Examiner it any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 s been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Other (specify) Pregnant at time of death 5 2 🗌 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 25 1 Yes ျ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on the 29b. Signatur d title of cert è 10x person who completed cause of death (Item 23a) (Type, Print Wusn -130A 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Lee Satterfield 07:57A M Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges' Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 9. Birthplace (State or Foreign . Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days 8. Date of Birth (Month, Day, Year) 04/04/1932 Hours 1 □ M 2 😾 F 78 578-50-7330 Director North Carolina Usual Residence of Decedent 10h County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director X☐ Yes 2 ☐ No MD PG Oxon Hill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 824 Shelby Drive 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Yes Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4yrs Maintenance Private æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pear Williams Drusie Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 Shelby Drive; Oxon Hill, MD 20745 Michael Satterfield - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/11/2011 Landover, Maryland Harmony Memorial Pk 22. Name and Address of Facility Freeman Funeral Services Signature Funeral Service Licensee 4594 Beech Road: Temple Hills, MD 23a. Part 1. Enjer the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Segmentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): use as the burial-transi attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) be detached signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No After this certificate has page 2 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2X No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who c

leted cause of death (Item 23a) (Type, Print)

32. Redistral's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 8:30 A M Elizabeth 2011 <u>March</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 201 Kerria Lane Middle River Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Hours 08/31/1927 New York **Director** 069-20-3710 83 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 Kerria Lane U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Elementary School Teacher Education æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ F. Charles Rousch Mary Agnes Pinney 1 and 2 should but the step and Me item 27 is mark other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Murphy / Sister 201 Kerria Lane, Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 03/16/2011 Hanover, Maryland Signature Funeral Service Licensee Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line iterval Between Onset and Death Immediate Cause (Final Physician/ Come disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) g physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Щ Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death ed by the detached g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2No 3 ☐ Probably 4 ☐ Unknown been sign 1 Yes Completed 24b. Were autopsy findings available 24a Was an Was a autopsy performed Jas prior to completion of cause of death? page certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA n 24 hours after death.

e Funeral Director: After the leted filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 No 1 Yes Accident Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Acrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and tite of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Franklin Square Waterfix 9103

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)
MAR 16 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 1, State of Maryland 1 Department of Health and Mental Hygiene 20 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day/ Physician/ Donald Marshall Sirasky Month 083JAM Medical 4a. Facility Name (if not institution, give street and rlumber)

Center **Examiner** 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTOWN BALTIMORE Age (In yrs. last birthday)
Yrs. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Month, Pay, Yan 2 Months Director 213-12-3723 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE BALTIMORE 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 4502 MARYKNOLL ROAD 21208 USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced WHITE Specify. Year or Dates. WW II event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Department of Health and Mental Hygiene. Important: If item 27 is marked other than "many injury or other traumatic." 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SHIPPING CLERK CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JACK SIRASKY FANNIE BERNSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIAN SIRASKY / WIFE BALTIMORE, MD 4502 MARYKNOLL ROAD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Complete) crematory or other place, ANSH F. EMILINAH CEM. 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 3/15/2011 BALTIMORE, MD 21. Signature of Funera 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between /h sicianجڙ Immediate Cause (Final Myorgidial Onset and Death disease or condition resulting in death) # Medical **Examiner** Atheroscierotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE use yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown for in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 □ No the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ₽No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 this certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: Certificate: To 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at after death. Director: After 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 28f. Location (Street and Number or Rural Route Number, Homicide To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Greensnon 4000011 Court (Month, Day, Year)
MAR 1 6 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH ALT.AN SCHWARTZMAN M. 2011 11:43 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MARYLAND MASONIC HOME HUNT VALLEY BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/21/1939 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Months Hours 1 M 2 □ F 220-36-4117 71 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. In wit: If item 27 is marked other than "natural", or items 23a or 28a-f show mit: If item 27 is marked other than "natural", or items 23a or 28a-f show Inty or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE HUNT VALLEY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 INTERNATIONAL CIRCLE, #203A 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify. Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESPERSON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OSCAR SCHWARTZMAN KERBEI 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILLIP SCHWARTZMAN / SON WESTMINSTER, MD 21158 536 RICH MAR STREET 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. BNAI ISRAEL CEMETERY 3/13/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Mars Ce 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) of **Physician** DIRATIM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transi Due to (or as a consequence of) physician the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an was a...
autopsy
performed?
Yes 2 2 No Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To o this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Division or Attending 5 ☐ Pending investigation Injury 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3-11-11

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBERT LIBERTO, NW. 3508 Bank St. Ballo, nul ZIZJY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Szamborski Physician 9:50 AM 09 2011 dward Mar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Hours M 2□F Maryland Director <u> 212-40-0136</u> 69 0ct Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1

Yes 2 □ No Md. Baltimore City Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number U.S.A. 620 South Milton 21224 Avenue Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Fi Yes 2 \(\subseteq \text{No} \)
If Yes, Give
Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 **V** T S Trucking Dispatcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Malczewski Edward Szamborski ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 616 Theodore Road Port DepositMd. 21904 George Noullet / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March Burial 2 Cremation 3 Removal from State 15,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St.Stanislaus_Cem 21. Signature of Funeral Ser 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A. 30 1201 Dundalk Avenue Baltimore, Md.21222 MM se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. L. Onset and Death SE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Colonic diverticulosis Examiner bra 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician; The law requires that the death certificate be executed burial-transit ding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year page 2 should be detached for a Pregnant at time of death 5 Other (specify) Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2. No 2 No 1 Yes 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death Check on one) Be Other: 2**X** No 1 Xinpatient 3 🗆 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes М 2 🗌 No filled in by the Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) the Hospital Funeral (x) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) matthe 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 6 2011 Registrar

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			For State Registrar	State of M	arylan		artment of H rtificate of L	Health and N Death		giene [] Reg. No.		08283
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	Examin		4a. Facility Name (if not institution,					Location of Death		4c. Count	ty of Deat	h
	uneral		Joseph Richey 5. Social Security Number 213-54-1237			ast birthday) Yrs.	Baltin If Under 1 Year Months Days		8. Date of Bir (Month, Da 09/24,		9. Bir Co Ma	thplace (State or Foreign untry) ryland
_			Usual Residence of Decedent 10a, State 10b, County		,	. T			05/24	7 1 1 1 1	1110	10d. Inside City Limits
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UUSO burs after deat	Department of result and wented by years. The many injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 🖾 Marr 3 ☐ Widowed 4 ☐ Divorced	If You City			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔼 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	ice - Ame ack, Whit ^{5/:} Whi	
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Description of the	tant: If ite		1 ☐ Burial 2 ☐ Cremation 4 🛛 Donation 5 ☐ Other (S		C	emetery, crer tany Gi	osition (Name of matory or other place fts Registr	y 03/1	Date 5/2011	1	er, N	Maryland
Dall permit	Import any inj once,		21. Signature of Faneral Service L	icensee				ss of Facility An				ry MD 21076
			23a. Part 1. Enter the disease, shock, or heart failure. List o								7001	Approximate Interval Between
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	aminer	L	Sequentially list conditions	Due to (or a	consequ	ience of):	- 505/5/4-0 - 0/26					
rted	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as	a consequ	ence of):						
be executed	attending physician and for use as the burial-transit	a	resulting in death) Last	Due to (or as	a consequ	ience of):				_		
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e death ce	the attend	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 - Feta	Ideath 3	Ctopic pregnand Cther (specify)	ey			ate of de lonth	livery Day Year
that th	gned by e detar	by Pl	Part II. Other significant condition	ns contributing to death b	out not res	ulting in the u	underlying cause giv	en in Part I.	23e. Did to	obacco use con	\ /	the cause of death?
aw requires	een sig	eted								Yes 2 No	<u> </u>	robably 4 Unknown
The law r	r this certificate has b aral director, page 2 sl	Completed									prior to death?	topsy findings available completion of cause of
ician:	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	ace of Death (Checker:				11
9 Phys	er this eral di	e: To	1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify)									ity) HOSPICE
Section Part Part												
LIVIS ital or Att	al Direct led in by		4 ☐ Homicide determ	ined 28e. Place of Injurbuilding, etc	c. (Specify,)	eet, factory, office	ļ	City or Tou	vn, State)		ral Route Number,
he Hospi in 24 hou	he Funer	Medical	(Check 2 L Medical E	Physician: To the best of examiner: On the basis of e Nurse Practioner: To the	xamination	and/or invest	tigation, in my opinio	on, death occurred at	the time, date a	and place, and d	ue to the	cause(s) and manner stated.
To t	Tot		29b. Signature and title of certifier	(. 12an			29c. License	0104267		29d. Date sign	ed (Mont)	
	0		30. Name and address of person v	who completed cause of d	eath (Item		Print)		0/ 11/0			<i>y</i>
	Stat	e	31. Date filed (Month, Day, Year)	1 CONTRA 32. Registra	DUA ar's Dignat	ure	1 leviden	the bies	a) ru	1180		
	olat Ponietra		MAR 1 6 2011	Palana	M	to a. N.	1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wonth Physician/ 4:42PM aura Medical nel 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 M 2 X F Days Hours (Month, Day, Year) 01/21/1966 Director 213-78-0089 Yrs 45 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1721 S. Hanover Street 21230 S.A items 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 'natural", Completed 3 Widowed 4 X Divorced Specify White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than " permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event, the May Elementary/Seconday (0-12) College (1-4 or 5+) Certified Nursing Assistant 12 Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Thomas Jackson Janet Lynn Schuvler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Jackson / Mother Hanover Street, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 03/15/2011 | Hanover, Maryland 21. Signature of Ineral Service Lid 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, shock, or heart failure. List mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mu disease or condition Medical resulting in death) a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical I Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has page 2 s autopsy death? 2 No 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 10 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Emergencu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rnes MD 31. Date filed (Month, Day, Year) State 32. Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener) For State Registrar Certificate of Death (First, Middle, Last) 2. Date of Death Physician/ March 201 nosamos 8:07A Medical 4b. City, Town, or Location of Death **Examiner** Anne lown tanover 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State **Funeral** 1**X**M 2 □ F Months Days Min. Hours Director Decedent 28a-f shov Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 No tanovei ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21076 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) erchan Be 17. Father's Name (First, Middle, 18. Mother's Name (First ပ inom ason 9b. Mailing A Town, State, Zip Code) 21076 and Number or Bural Route Nu nompson lown 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9-2011 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ (angiv Medical resulting in death) Examiner Coronary HEART Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of burial-transit CARDIAL Cause (Disease or linjury that initiated events ARREST Due to (or as a consequence of): resulting in death) Last attending physiciar the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTEMITON 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sl
completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? Yes 2 N 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1. Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Contributing Number Pranticion: To the course of my new local production of the cause of the (Check only one) 29c. License number 29d. Date signed (Month. Day. Year) D38086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57 620 BALTE. W. Riphold 5-14, 31. Date filed (Month, Day, 2. Registrar's Signature 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 50 A M eona apper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE BALTIMORE NORTH OAKS HEALTH CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 0472771918 93 Director 298-03-1990 Usual Residence of Decedent 28a-f show . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27 is marked other than "natural", or items 23a or 28a-f sho lary or other traumatic event, the Medical Examiner must be notified at Jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 725 MT. WILSON LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify Completed 3 ₩ Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ARTIST ART Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROSSEN SIFF DORETHEA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE TREEWATER/DAUGHTER 22 KEEL COURT, SAN RAFAEL, CA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 4 Donation 5 Dother (Specify) ROSE HILL CEMETERY 03/13/2011 FAIRLAWN, OHIO 21. Si nature of Funeral Service Licen SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications of shock, or heart failure. List only one cause of Immediate Cause (Final Onset and Death Physician/ ementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death be detached signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed 2 No 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 V No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work?
1 Yes 2 No Accident Investigation after death Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 [only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hierme 31. Date filed (Month, Day 32. Registrar State MAR 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month March Physician/ 2011 06:58 A M Rhonda Lyn Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel 8 Southfield Road Glen Burnie 8. Date of Birth (Month, Day, Aptil 7 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Months Hours 1966 213-88-4259 Yrs 44 Director Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Glen Burnie Maryland Anne Arundel 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Officers and Albertal Hygiene.
marked other than "natural", or items 23a or Funeral 21060 USA 8 Southfield Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No If Yes, Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Disabled Never Worked 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Thiel Leslie Nickey Joseph Lyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Southfield Road, Glen Burnie, MD 21060 Leslie L. Lilly (mother) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State March 14 Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Ligense 3111 Mountain Road, Pasadena, MD 21122 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Approximate Interval Between One t and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last s been signed by the attending physician should be detached for נוכם איני בייירי Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has Been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performes 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1X Natural 1 🗆 Yes 2 🗆 No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

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who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08288 State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2.011 7:45 Рм Emily May Williams March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arden Courts Assisted Living Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Maryland 1 □ M 2 🗓 F Months Days 213-26-6880 81 November 18,1929 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Parkton Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , 23a r Funeral 21120 17112 Masemore Rd. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Jo. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 ☐ Divorced Specify: white Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elsie Hagy Lawrence Leeson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Leeson/brother 21152 24 Sparks Station Rd. Sparks, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory Mar. 15,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) John O. Mitchell IV, Funeral Services of Dulaney Valley, Timonium MD 21093 P.A. 21. Signature of Funeral Service Licensee 200 E. Padonia Rd Timonium, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-1 Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 200 certificate 1 🗌 Yes 2 🗌 No Division of Vital Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year THERESA Physician MNTER 6:20 A M 2011 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 2, 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 💢 F Maryland 219-30-6650 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 👿 No Director Sparrows Point Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21219 USA 2402 1/2 Lodge Forest Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Cashier 2 years 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Hoesch George Zinner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2402 1/2 Lodge Forest Drive, Spanrows Point, Maryland 21219 William L. Winter Sr. Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 17, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland Sacred Heart of Jesus Cem., 2011 21. Signature of Funeral Service License connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 M01176 23a. Part 1. Iter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Infarction Due to (or as a consequence or /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and d for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 1 Live birth 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 2 No 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation Natural Injury 1 🗌 Yes 2 No death. 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 14, 2011 RES-000

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State Registrar MAR 16 2011

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001 11595 4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Physician/ 7:35 PM WILLIAMS ERONICA 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E. 32nd STREET BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Cv BA 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 🗆 M 2 🔀 F 8 2 Yrs 01-10-1929 057-30-6662 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1X Yes 2 No BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 Funeral USA 2001 E. 32nd STREET Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Black White etc. 1 Never Married 2 Married Ď 1 XIYes 2 No Specify: CUBAN BUACK 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' HEALTHCARE College (1-4 or 5+) Elementary/Seconday (0-12) er Fusionist injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ STANLEY ELIZABETH KING McLeod 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trauonce. 2001 E. 32nd St. BALTO, MD. 21218 Patricia Burwell DAUGHTER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition Surial 2 ☐ Cremation 3 ☐ Removal from State 3/18/11 BALTIMORE, MD GARDEN OF FAITH 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUSHN GREENE FUNERIN SCIS 4905 YORK ROAD, BALTIMORE, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Promician/ MA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No The law requires that the death Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 Yes 2 No 1 Yes 21 To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \(\text{Nursing Home} \) \(\frac{1}{2} \) Residence \(6 \) \(\text{Other} \) (Specify, 1 Tes 2 [1] M 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier awsm M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARRISON Joseph Rucky Hospi cu 31. Date filed (Month, Day, 32. Registrar's Signature State 2011 16 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #788 Per Fh G913 3/21/2011 JH. State of Maryland / Department of Health and Mental Hygien? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 March Physician/ 7:00 A M Colleen A. Wagner 13 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 1416 Francke Avenue Lutherville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1948 Aug. 21, 1947 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours 1 M 2 X F 219-56-6961 63 Maryland 62 Director Yrs Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Lutherville Md Baltimore o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Francke Avenue 1416 21093 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify. "natural" Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any rijury or other traumatic event, the Meagnes. Elementary/Seconday (0-12) College (1-4 or 5+) Accounts Receivable Management Alliance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert W. Smith, Sr. Patricia Dver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Wagner/Husband 1416 Francke Ave. Lutherville, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/18/11 Forest Hill, Maryland Ignatius Cem. . Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 7am 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Immediate Cause (Final OVARIAN ARCINOMA Physician/ disease or condition Col Medical resulting in death) Due to (or as a consequence of) Examiner DOD 3/13/2011 Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ng physician and as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE for use Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Wagner the 9 Unknown detached 9 Unknown of Vital Records, P.O. To the Hospital or Attending Physician, the law learn within 24 hours after death.

To the Funeral Director: After this certificate has been signed by (completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Colleen performed? 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL FOSTER, MB 6565 W. CHA N. CHARLES, #203. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 6 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11:45а м Physician/ 020/26/2011 Paityn Wainwright Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** 621 East 41st Street 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 D M 2 X Hours Min. Baltimore Pays (Month, Day, Year) 02/16/201 Unavailable Director Usual Residence of Decedent 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County Director Baltimore Baltimore MD 1X Yes 2 ☐ No 10g. Citizen of What Country?
USA 10e. Street and Number 10f. Zip Code 21218 by Funeral 621 East 41st Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ※ No If Yes, Give 14 Race - American Indian. 11. Marital Status Black, White, etc 1 X Never Married 2 Married Black ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dependent Dependent Be 18. Mother's Name (First, Middle, Maiden Surname)

Jasmin Stockhausen 17. Father's Name (First, Middle, Last) Perry Wainwright 2 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 East 41st Street Baltimore MD 21218 19a. Informant's Name/Relationship (Type, Print) Jasmin Stockhausen Mother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Atlantic Crem 2/28/2011 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilitSimplicity Crem & Fun Serv ThomasAllen PA 7090 Ridge RD HanoverMD Signature of Juneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) SUM **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has perform 2 No 1 🔲 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home ၉ 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 only one) 29c. License number 31. Date filed (Month, 6 20 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 5 per fh 9913 3-29-11 vt. State of Maryland / Department of Health and Mental Hygiene 0 1 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IERRY 11:18 PM 13,5011 ORAW HORL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UU4 ARUNDEL BALTIMORE-WASHIHETOH MEDICAL CEHTER GLEN BURHIE 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Days Hours Country)
Maryland Director -54-6834 March 1949 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No <u>Maryland</u> Anne Arundel Glen Burnie ò 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be. Funeral 1216 Kenwood RD. 21060 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔯 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) +4 IT Specialist Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter William Ward Louise Portscher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 Frank Chang / Domestic Partner 1216 Kenwood Rd. Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 16,2011 Catonsville, Maryland Mar. 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy. re of the eral Syrvey License Funeral Home, P.A. SE: Glen Burnie, MD 21061 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ SELLIC SHOCK MEEK Medical Due to (or as a consequence of) Examiner AIUOM UBUS 24AD 0. Sequentially list conditions, if any, leading to immediate cause. E. Lei Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) 4 Pregnant a Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ເ No 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 🔀 No ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. пpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29c. License number 29d. Date signed (Month, Day, Year) OH commenter asing your HD D0065+1A MARCH 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUILLERMO JOSE GIANGRECO 301 HOSPITAL DRIVE, CLEN BURNIE, MD 20161-5803 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items I per doc, 18 per fh g913 3-31-11 vt. State of Maryland / Department of Health and Mental Hygiene of it For State Registrar Certificate of Death Reg. No. George Allen Williams 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 25AM 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** General hospital Howard County (plumbia Howard If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours 1 🛛 M 2 🗆 F 04/29/1927 83 MΙ **Director** 369-22-6779 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 XNo ELLICOTT CITY MD HOWARD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò "natural", or items 23a or edical Examiner must be Funeral 21042 USA 2613 JONATHAN ROAD Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give 3 Divorced WHITE Completed Year or Dates and Mental Hygiene.
is marked other than "naturaumatic event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DEFENSE ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maideo Surname) **LYDIA ELVIRA ANDERSON** ပ JOHN EDWARD WILLIAMS JANE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21042 2613 JONATHAN ROAD, ELLICOTT CITY, MD JANE WILLIAMS/WIFE or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 1 Nurial 2 Cremation 3 Removal from State injury MARYLAND VETERANS 03/15/2011 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Services Licen e SOL LEVINSON & BROS., INC. any rom 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): pullation Examiner malor Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Yes 9 Unknown been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed icate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No After this certificate Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: atural 5 Pending 1 ☐ Yes 2 ☐ No in 24 hours are: ____the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30641 lann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rameh Sabapalli Del-109 Rack Run Melk Road Balline Maylar Rameh fabepally 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 435 AM Wanda Winnett 14 2011 3 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rosedal BalTimore FRANKLIN SQUERE HOSPITAI 1 Year | If Under 24 Hrs. | Days | Hours | Min. | 8. Date of Birth (Month, Day, Oct 31, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Maryland 1 □ M 2 🔏 F Months 219-20-7444 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Presion Event in must be invited at 1 □Yes 2 🙀 No Funeral Director Md. Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 21236 4300 Cardwell Avenue, Apt 125 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2X∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify: ģ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Mental is marked Peter Siarkowski Sierak Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) U 188 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any injury or other trau once. Son 2038 Fairway Crossing Drive, Woodstock, Ga. Daniel R. Winnett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marct Burial 2 Cremation 3 Removal from State Holy Rosary Cem. 17, 2011Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilik aczorowski Funeral Home, P.A. 21. Signature of Funeral Service License Bound 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ZWEEKS Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐Yes 2 ☑No Division of Vital Records, P.O. 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☑No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical Be 26. Place of Death (Check onl. one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH H, 2011 063054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKUN SQUARE DRIVE, BALTIMONE, MAJID CINA, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 6 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BASIL 15PM MARCH CKANICZ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington MEDICAL (BALTIMORE ANNE ARUNDEL GLEN 8. Date of Birth (Month, Day, June 12, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (in yrs. last birthday) **Funeral** Hours 1 🛛 M 2 🗆 F Days Pennsylvania June [937 Director 204-28-4409 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Odenton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21113 646 Chapelgate Dr. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced White Year or DatesArmy injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Food Industry Butcher 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Super Nicholas John Yackanicz Ann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Odenton, MD 646 Chapelgate Dr. Nicole Araujo / Daughter 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) □_ABurial 2 X Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 3/18/2011 Catonsville, Maryland Metro Crematory livre of Ruperal Se vice Licent ee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P., 421 Crain Hwy. SE; Glen Burnie, Sign 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final NFARCTION Physician/ MYOCATOLA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner YRS Sequentially list conditions. rf any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Year Month Day Pregnant at time of death 4 ☐ Pregnama 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b ; page 2 sl autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate h
completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 24 Nn မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife 13 2011 MARCH My

State Registrar

DHMH 17 Rev 7/2009

MADISON PARK DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tom45 H. AYACA m 1917 MAD SON F

32. Registrar's Signature

TOMAS H. AYALA

31. Date filed (Month, Day, Year) **MAR 1 6 2011**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar		State of	iviai yiai		ertificate d				Reg. No		
Physician		1. Decedent's Name		ast) ADAMS						2. Date of Dea			3. Time of Death
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Funeral Director		5. Social Security No. 091-60-0 Usual Residence of	352	Sex 1 ☐ M 2 🂢 F	Age (In yrs. i	last birthday) Yrs.	If Under 1 Y	ear If Un ays Hour	der 24 Hrs. 's Min.	8. Date of Birt (Month, Da Nov 1	y Year)	960 9. Birti Cou Ne	hplace (State or Foreign Intry) EW York
and show	- I	10a. State	10b. County		10c. Cit	ty, Town or L	ocation						10d. Inside City Limits
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permit. Departr Imports any injt	ľ	21. Signature of Fur	neral Service Lice	msee M	00689	2	22. Name and A	ddress of Fa	^{icility} DeV Park	7ol Fund Dr. Gai	eral ther	Home	MD_20877
Physician/		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on ea if line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Onset and Death										Approximate Interval Between	
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uires that the nation of his details and he details he details he	60 00	Part II. Other signif	icant conditions	contributing to dea	th but not res	sulting in the	underlying caus	se given in F	Part I.	23e. Did to		V	the cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Marinal Certificate: To Be Completed by Dhysician/Medical Exam	ompie.									24a. Was autor perfo		prior to death?	topsy findings available completion of cause of
ician: T	3	25. Was case referre	1	Hospital:			2	0	Death (Check	(only one)			
ling Physi After this c uneral dire		1 ☐ Yes 2 ☐ 27. Manner of Death 1 ☑ Natural	No n 5 Pending	1 ☐ In 28a. Date of		ER/Outpation 28b. Time injury		4 ∟ Injury at work?		ime 5 AResid 28d. Describe h		Other (Speci y occurred	ify)
after death. Director: After the in by the funera		2 Accident 3 Suicide 4 Homicide	Investigat 6	t be 28e. Place of	f Injury - At ho , etc. (Specif		M treet, factory, of	1 ☐ Yes 2	100	28f. Location (S City or Tou			ral Route Number,
he Hospita in 24 hours he Funeral ipleted filled	Calcal	(Check 2	Medical Exa	hysician: To the bes miner: On the basis urse Practioner: To	of examination	on and/or inve	estigation, in my o	opinion, deat	h occurred at	the time, date a	and place	e, and due to the o	cause(s) and manner stated
vithir vithir comp		29b. Signature and		7		·, · · · · · · · · · · · · · · · · ·	2 9c. Lic	cense numb	er		29d. Da	te signed (Month	, Day, Year)
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		30. Name and address 31. Date filed (Month	7 D. 1	Lotistain	istrar's Signa	mi	bokins	Unu	, (55	N. WEll	E B	meltmen	·11 Md 2/205
State Registrar		MA	R 0 1 201		Duran a Signa	Ap con	A. S. Carlot						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

11-01813 Sally Jo Andrew Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08298 State of Maryland / Department of Health and Mental Hygiene amend #19a Per FH Certificate of Death JH 1- For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1636 hrs Medical Examiner Sally Jo Andrew March 6, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 903 Fairhaven Court Federalsburg Caroline 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. Aug. 27, 1964 Director MD 46 213-92-5353 1 M 2 XF Country Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Au 10a, State 1 X Yes 2 No Federalsburg 28a-f show Caroline within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 United States 903 Fairhaven Court Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No White 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lowes Company 21215-0036 Cashier 12 of Health and Mental Hygiene.

If item 27 is marked other tl 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filed B Joseph Andrew Sallie Muir ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 11766 McDowell Lane, Greenwood, DE 19950 Brittany Ross/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place Bunial 2 Tremation 3 Removal from State 03/09/11 Cambridge, MD Mid-Share Cremation Ctr. Department Important: Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Morphine Intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as e consequence of): if any, leading to immediate cause. Enter Underlying Cause Exam (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,28a-f per me g913 3-30-11 vt X UNPENDED attending physician or use as the burial Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery . Was decedent pregnant in the 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ≥ 1 Yes 2 No 3 Probably 4 V Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed' Yes 2 No 1 🗸 Yes certificate Hospital or Attending Physician; 26. Place of Death (Check only one) of Vital 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 this No 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural Division c Funeral Director: A letely filled in by the fu 1 Yes 2 X No Pending unknown fd 3-6-11 fd 4:30pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 903 Fairhaven Ct. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide determined residence Federalburg, Caroline Co., Md Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME March 7, 2011 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 3 6:40 P M **Physician** 201 is /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (It not institution, give street and number) Examiner Anne Arundel Annapolis Somerford Assisted Living Annay B. Date of Birth (Month, Pay, Aug. 13) 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex ^{Year)}922 **Funeral** Months Days Maryland 1 □ M 2XX 216-16-4946 88 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Annapolis Maryland Anne Arundel 1 ☐ Yes XXNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21401 231 Cape St. John Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣CXNo If Yes, Give 11. Marital Status Black, White, etc. be filed within 72 hours after 1 □ Never Married 2 □ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 2 3√Widowed 4 ☐ Divorced Year or Dates: Be Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) it of Health and Mental Hygiene.
If Item 27 is marked other than '
or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Reed Joseph B. Lincoln Pages 1 and 2 should nent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 231 Cape St. John Road Annapolis, Maryland 21401 Suzanne Sitar/daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition ъ 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3/1/2011 Baltimore, Maryland permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Se 100 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years **Physician** advanceo resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): The law requires that the death certificate be executed Exam sician and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 □ Yes 2 □ Mo ed by the Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed h 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an has this certificate 10 Yes To the Hospital or Attending Physician: assisted 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 1 ☐ Yes 2 4 ☐ Nursing Home 1 Inpatient 2 ER/Outpatient 3∏ DOA 5 Residence 6 Dother (Specify) 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural (Month, Day Year) Injury 5 Pending Investigation 1 □ Yes 2 □ No death. Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide after within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature an vansttuy Millers V. lle MD 2/108

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien 2. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 24, 2011 Year Physician/ 6:50 PM Bridges Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 6406 Old Sandy Spring Road Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F Days Months Hours Min. November 26, 1921 North Carolina **Director** 89 578-20-2008 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland 1 Prince Georges Laure1 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral TISA 20707 16201 Kent Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural", Completed 3 X Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nould be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dispatcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amelia Beaslev ည William Hays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16201 Kent Road, Laurel, Maryland 20707 Linda Spindler-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important; If any injury or Laurel, Maryland Ivy Hill Cemetery Feb. 28,2011 4 Donation 5 Other (Specify) 21. Signature of Fupera Service Licensee Fleak Funeral Hade, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Once and Death years Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 15 years Hypertension Heart Disease Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immedicause. Enter Underlying Chronic Obstruction Pulmonary Disease 5 years Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): 2 years Physician/Medical Dementia The law requires that the death certificate be P,O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an page 2 s has performed? Yes 2 A No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \undextbf{X} Other (Specify) 1 Tyes 2**X** No ည Assisted 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Living Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 □ Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

40

DHMH 17 Rev 7/2009

State Registrar B.G. Manejwala, MD V 1 31. Date filed (Month, Day, Year) MAR 0 1 2011

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

D13671

14201 Laurel Park Drive, Ste 102, Laurel, Maryland 20707

February 25, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ :40AM Broome oreat Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death, 4c. County of Death Examiner Calver. County Nursina Prince Frederick Center Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex . Age (In yrs. last birthday) Funeral 218-28-2376 1 □ M 2 💢 F Days (Month, Day, Country) 88 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔊 No Calvert LUSB MD 6 10e. Street and Number 10g, Citizen of What Country? Funeral 20657 23a USA 476 Bafford items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. o. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: marked other than "natural", 3 X Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seatood Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, ဨ Dorse Ada Hutchins Edgar permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is marⁱ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll daughter 8916 Church Ln. Kandallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mar. 4,2011 St. John UMC Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Home P.A. 22. Name and Address of Facility 5ewell Beach Rd. Prince Fred. 1451 Dares 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FAILURE THRIVE TO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner AMPUTATION KNEE THE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine VASCULAR PERIPHERAL burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours Medical ECertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 50033 30. Name and address of person who completed cause of death (trem 23a) (Type, Print) LRW Dr. #310 Prince Fred, MD20678 M.D. 110 oody Dital 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Month FEB Physician/ 21 5:20 A M CALVERT POTTER BENEDICT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER 8. Date of Birth May 26, 1924 7. Age (In yrs. last birthday) 86 yrs If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe **Funeral** Days Hours Min. 534-38-6899 1**X**□ M 2 □ F Months West Point, NY Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10c, City, Town or Location Director X Yes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code 20015 10e. Street and Number Funeral 6200 Oregon Ave, N.W. #321 12. Was Decedent Ever in U.S. Armed Forces? 1943 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11, Marital Status Armed Forces? 1943
1 Xyes 2 No
1981
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Specify: White Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Cellege (1-4 or 5+) US Army Major General Be 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Potter 17. Father's Name (First, Middle, Last) Charles Calvert Benedict 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6200 Oregon Ave, N.W.#321 Washington DC 20016 Gene Ferris Benedict/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗌 Burial 2 🔁 Cremation 3 🗆 Removal from State 2-26-2011 Falls Church, VA 4 Donation 5 Other (Specify) National Crematory 22. Name and Address of Facility Joseph Gawler's Sons, INC Signature of Fuyleral Service Licensee 5130 Wisconsin Ave, Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ SEPSIS Medical resulting in death) Due to (or as a consequence of): **Examiner** BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events METASTATIC PROSTATE CANCER Due to (or as a consequence of) resulting in death) Last buria the attending physician thed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No tor: After this certificate has been signed by the at the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tyes 1 M Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

20

29b. Signature and title of certifier

Day, Year)

MAR 0.1 2000

JONATHAN A. 31. Date filed (Month.

MM

A106299 (CA)

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

J. Bolanos,

MC

2. Registrar's Signature

USN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOLANOS

LT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08303 State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 р м Eleanor Medical Becker 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery

9. Birthplace (State or Foreign <u> Montgomery General Hospital</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funeral 8. Date of Birth Months Days 1 🗆 M 2 😾 F Hours Min. Oct. 5, 1936 Country) D.C 74 Director 220-32-5702 Yrs Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 N. Leisure World Blvd., #129 20906 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White 3 S Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ William Henry Miller Nora Cecilia Scanlon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Becker/Son f Health 12711 Prospect Knolls Drive, Bowie, MD 20720 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State March 4, Orantico Nat'l Cemetery 4 Donation 5 Other (Specify) 2011 Triangle, VA Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring 21. Signature of Funeral Service Licens any MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition mins Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) physicans the burial transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Other (specify) Month Year 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 Tes Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D38457 Feb. 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nakul Goyal, MD3801 International Drive, Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08304 State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month O Physician/ Rita Margaret Bosse 0520M 201 Medical 4b. City, Town, or Location of Death 4c. County of Death • 4a. Facility Name (if not institution, give street and number) **Examiner** HIGINIO 544136414 TENIN SULLA If Under 1 Year If Under 24 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Country) CT 1 □ M 2 🏲 F Months Hours Min. 9 Manty, Day, 9940 70 041-32-5627 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 No Worcester Berlin MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 USA <u>77 Newport Drive</u> Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give δ 1 Never Married 2X Married Maryland 21215-0036 e filed within 72 hours after tal Hygiene. ed other than "natural", o 1 ☐ Yes 2 ☒ No Specify: white 3 - Widowed 4 - Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dietary Supervisor Danbury Hospital permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked othe any injury or other traumatic event; Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Theresa Speh Walter Heagney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Berlin, MD_{-} 21811 Robert R Bosse Husband Newport Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State First State Crem. 3-1-2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home . Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William Street Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final Orniv Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No q 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
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1 Yes 2 No М 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cortifying Nurse only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 2/28/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll St. Salisbury, m.D. 21801 DN 5 Snyd C MC 100 €. State Registrar

11-01364 Aaron Patrick Brown

1- For State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 08305 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

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		failure. List only one cause on each line.				Death Death	
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3	Σ	29b. Signature and title of certifier			February 18, 20		
		Celul VI	O.C.M.E.		eviualy 10, 20		
		30. Name and address of person who completed cause of death (Item 23a)					
		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Ba	Itimore Street, Baltimore	, MD 21223			
	ate	31. Date filed (Month Dax Year) 32/Registrar's Signature	A.				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 08306 State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONX -0 Q Omo 5. Social Security Number Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. JAN 10 4 1915 577-05-3465 Brunswick, MD Director 96 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Prince Georges Hyattsville 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3107 Kelliher Road Hygiene. other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in LLS. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of Bernard Hill Flossie Albert permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10611 Greenwood Drive, Spotsylvania, VA 22553 Barbara Dickinson, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Park Heights Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or 2/26/11 21716 Brunswick, MD 4 Dowation 5 Other (Specify) 21. Signa Name and Address of Facility
John T. Williams Funeral Home
100 Petersville Road, Brunswick, Williams, Owner 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ordenying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phy: the use as yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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3 Suicide 5 Pending within 24 hours after death. To the Funeral Director: A 1 Tyes 2 🔲 No Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 105

Box 68760

P.O.

Division of Vital

State Registrar 31. Date filed (Month, Day,

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ess of person who completed cause of death (Item 23a) (Type, Print)

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ceath certificate be attending physicifor use as the buri	ĕ -	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 23c. If yes, outcome of p 1 Live birth 4 Pregnant at time of p 9 Unknown	2 Fe	etal death 3	Ectopic pre	gnancy	23d. Date of deliver Month	y Day Year
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10	;	30. Mame and address of person who completed cause of death (Russell Alexander MD. Assistant Medical Ex		W. Baltimor	re Street, Bal	timore, MD 212	223	
Sta Registr	te ar	31. Date filed (Month, Day Year) 8 2011 32. Resistrar's Sig	inature /	ash	Ü	UNE		

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MD 2 d 2 shoul lith and M n 27 is m	To	Jesse L. Bri	ttingham Sr	c. father	3546 Ch	ateau Dr.,		Market, MD	21631	
e, M and 2 Health item 2		20a. Method of Disposition			ace of Disposition (ematory or other pl	Name of cemetery, ace)	Date	20c. Location - City	or Town, State	
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COLO law re has be	Completed						p	erformed? deat	h? Yes 2 No	
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Division of Vital Records, ra for death. The law requirer after the death. After this certificate has been siled in by the funeral director, page 2 should fell in by the funeral director, page 2 should fell.	ΙĒ	27. Manner of Death	28a Dat	te of Injury th, Day Year) 2, 2011	28b. Time of Injury		Subject s	ibe how injury occurred shot self		
ion itendii leath. tor: A	atio	1 Natural 5	rending			1 Yes 2		on (Street and Number of	or Rural Route Number, City	
ivis or At after d Direc	Certification:	3 ✓ Suicide 6	Could not be			actory, office building,	or Tow 5521 Aire	m, State) ys Road, Cambridge,	MD	
Di ospital hours a necral I			The state of Tanks by	(v) Local Street	ge death occurred	at the time, date and	place, and due to the	cause(s) and manner as	stated.	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys commelest filled in birth the timeral director, page 2 should be detached for use as the b	Medical	(Check only one) 2 Medical	Examiner: On the basis	s of examination a	nd/or investigation	in my opinion, death	occurred at the time,	rate and place, and doc	(5 (75 caass(s)	
To To	Me	29b. Signature and title of c	and manner ertifier	stated.		29c. License numb	per		(Month, Day, Year)	
0		11/1/6		11)	O.C.M.E.		February 23,	2011	
1,4		30. Name and address of pe		ause of death (Item	1 23a)	Raltimore Street	et, Baltimore, MD	21223		
\		Russell Alexander		Medical Exan			St, Daitimore, MD			
Boo	Stat	31. Date filed (Month, Day)	8 2011	Togistial s olylial	1. box		(ic:			

Amend #26 per PHY 08309 AACO Health Dept. 2-23-11 KAH State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Blakeslee 8:45 PM Son 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MD Anne 1132 Generals Highway 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Oct. 21,1921 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 XM 2 □ F 89 Director 195-16-1710 Pennsvlvania Usual Residence of Decedent 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location Director Clearfield DuBois 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 500 South 4th Street 15801 USA ıral", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 👿 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 😾 Widowed 4 🗌 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of health and Mental Hygiene. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Medical Doctor Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Colson E. Blakeslee, Sr. Mabel Fye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Mark Blakeslee / Son 780 Hardscrabble Lane, Lewisburg, PA 17837 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State February 21 Morningside Cemetery 4 Donation 5 Other (Specify) DuBois, PA 2011 21. Signature of Funeral Solvice Licenses P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 28a. Part . Enter the disease, or shock, or heart failure. List of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Kena tcute disease or condition resulting in death) Medical Examiner onaesti Sequentially list conditions, Certificate: To Be Completed by Physician/Medical Examine Due to (or a a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transil that initiated events resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Daughter's 2 No 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 042146 20 30. Name and address of person who completed cars of death (tem 23a) (Type, Print) Severna Par Eichelberger MD 31. Date filed (Month, Day, Year) FEB 2 3 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Charles M. Boston February 2011 1900 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Months Days Min. (Month, Day, Year) Marvland Director 578-04-4766 Dec Usual Residence of Decedent Juld be filed within 72 thousand Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show anaked other than Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MarylandPrince George's Ft. Washington 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1602 Brakefield Ct. 20744 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Basketball Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H ပ Charles S. Boston H. Marie Sewell Lepartment of Health and Important: If item 27 is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)2074419a. Informant's Name/Relationship (Type, Print) Debra Boston(Wife) 1602 Brakefield Ct. Ft. Washington, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem ! 2-28-11 Clinton, Md. Signature of Funeral Service Licenses MM Mame a Reachescof RecilitSons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 M. Reas Larry A10048 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause or each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to yr as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death ed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical of Vital æ 26. Place of Death (Check only one) Other: 1 Yes 2 💢 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Division within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident
Suicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day), The completed cause of death (item 23a) (Type, Print)

Registrar

State

31. Date filed (Month,

Day, Year) 2 8 2011 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 20C John Melvin Burns Medical 4a. Facility Name (if not institution, give street and number) Examiner If Unde If Under 1 Funeral 1 **x** M 2 □ F Months Days Hours 4/14/1928 Country) 216-22-3308 Director 82 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Anne Arundel Severn 1 ☐ Yes 🗶 🗓 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 1528 Florida Ave. 21144 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 KWes 2 \sum_{No} Korea Black, White, etc. 0 1 Never Married 2XXMarried δ White 1 Yes XX No "natural", If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Carpenter Giant Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Henry Patrick Burns Violet Blanche Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Helen Burns Wife 1528 Florida Ave. Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1xx Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Maryland Veterans Cem 2/28/2011 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Hardesty Funeral Home, P.A. Jall 851 Annapolis Rd. Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (o Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): bunial Physician/Medical nding phys IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death signed by t. d be detach Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 25. Was case referred to medical the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work iours after death.

neral Director: Aff
filled in by the fur 1 Yes Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08312 State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 25,2019 Physician/ 1501 Betty M. Brooks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) 12/31/1930 1 M 2 X 577-40-6298 80 Director Washington DC Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Anne Arundel Deale 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5900 Rockhold Drive 20751 USA 12. Was Decedent Ever in U.S Was Deces Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes : Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: Specify: 3 Widowed 4xxDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Shipping Elementary/Seconday (0-12) College (1-4 or 5+) Stock Clerk permit. Page 1 and 2 should be filled wit Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, ths once. 08 Be 18. Mother's Name (First, Middle, Maiden Surname)
May Florence Wilson 17. Father's Name (First, Middle, Last) ည George D. Boswell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26190 Shore Highway Denton, MD 21629 19a. Informant's Name/Relationship (Type, Print) Beverly A. Damiloski Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/28/2011 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility
Hardesty Funeral Home P.A. Galesville, MD 20765 ervice Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Que to (or as a nonsequence of) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death by the detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖸 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

State Registrar 31. Date filed (Month, Day, Ye

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(100

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 3 per med cert G914 47 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2 0 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month March Day 12:45 P M Physician/ 2011 Covey Christine J. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil E1kton Elkton Care If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth 6. Sex **Funeral** (Month, Day, Year), Dec. 9, 1946 Hours 1 □ M 2 🗆 XF Months Utica, NY 64 Director 113-40-6912 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director E1kton 1 Yes 2 No MD Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21921 77 Hollingsworth Manor Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White, etc. Completed by 1 Never Married 2 x Married 1 ☐ Yes 2 🔯 No If Yes, Give Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Delaware Veterans Elementary/Seconday (0-12) College (1-4 or 5+) LPN Memorial Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Eva Taftt Robert Ranseer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21921 Elkton, MD 77 Hollingsworth Manor John P. Covey (husband) Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Delaware Veterans 4 Donation 5 Other (Specify) March 10,2011 Bear, DE Name an direst of Facility Signature of Funeral Service Licensee MOOK McCrery & Harra Funeral Homes and Crematory, Inc 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Indiana Cause) Approximate Interval Between Obstructive Kulmonary Onset and Death Ph_sician/ years disease or condition resulting in death) Medical Examiner Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O, Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an nis certificate has b I director, page 2 sh autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tite of certifie 29c. License number 3.1.2011. Sushday-S. M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 126 A E S. S. SACHDEN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Manua		partment of Health and N		•	
			_ State		ertificate of Death		2011	08314
			Registrar 1. Decedent's Name (First, Middle, Last)		Fillicate of Death	Reg. 2. Date of Death	. No.	2 Time of Dooth 0
	Physicia Medic		CHARLES CLE	VELA	ND COLEMAN	Month	Day Year	3. Time of Death ρ
	Examir	ner	4a. Facility Name (if not institution, give street and number) CHESTER RIVER HOSPI		4b. City, Town, or Location of Death	=0.T=11)0/	4c. County of Dear	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		219-60-1802	58 Yrs.	Months Days Hours Min.	09/24/19	52 MA F	RYLAND
	land show dat	5		City, Town or L	ocation			10d. Inside City Limits
	Maryl 28a-f ptified	rec	MD KENT CE	HESTERT	OWN			1 🗆 Yes 2 🗶 No
	a or 2	Ö	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	ountry?
	h with	Funeral Director	22915 BAY SHORE ROAD		21620	ט	NITED STA	ATES
	deat riten inerr		11. Marital Status 1 □ Never Married 2 X Married 12. Was Decedent Ever in UArmed Forces? 1 □ Yes 2 X No	U.S. 13.	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	al", o	d by	1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give If Yes, Give Year or Dates.		1 ☐ Yes 2 X No Specify:		Specify	
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at	Completed	15. Decedent's Education	16a. Decr	edent's Usual Occupation	16	b. Kind of Business	Industry
215	in 72 e. nan "ı	m	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give	e kind of work done during most of worki DO NOT use retired)	ng		,
	J within ygiene. her tha it, the N	Be C	12	HOUS	E PAINTER	P	AINTING	
gue	be filed ental Hy ked oth ic event	To B	17. Father's Name (First, Middle, Last)			e (First, Middle, Maio		
Z Z	क्र केंद्र ⊴		CHARLES FORD COLEMAN			CES MEEKI		
Maryland	2 shoulth and 27 is m		19a. Informant's Name/Relationship (Type, Print)	1.5	ling Address (Street and Number or Rura 5 BAY SHORE ROAD C			
ē	F Hearlitem		KAREN COLEMAN - WIFE 20a. Method of Disposition 20b	. Place of Disp	osition (Name of		c. Location - City or	
Baltimore,	~ ~	П	1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ernatory or other place) KE CREMATION 02/2		•	
alti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee		22. Name and Address of Facility ELLOWS, HELFENBEIN			
8	P P E E		* Keck of Selfubin	1	30 SPEER ROAD CHES	TERTOWN,	MARYLAND	21620
			23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause an ach line.	ath. Do not en	ter the mode of dying, such as cardiac of	r respiratory arrest,		Approximate Interval Between
F	h sician/	i i	Immediate Cause (Final disease or condition	node	my willen			Onset and Death
1	Medical Examiner		resulting in death) a. Due to (or as conse	equence of):	lung cano	_		± /\
		er	Sequentially list conditions, b. Due to for as a conse	<u> </u>	lung Clini	er		months
	red nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	request to en units				
	s be executed /sician and s burial-transit		that initiated events c. Due to (or as a conse	equence of):				
0	e be e ysicia e buri	lical	d					
Box 6876	tificat ng ph as th	Med	IF FEMALE:					
9 ×	th cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	etal death 3	Ectopic pregnancy		23d. Date of de	
Bo	ss that the death certificate igned by the attending phy be detached for use as the	Physician/Med	1 Yes 2 No 9 Unknown	of death 5 l	Other (specify)		Month	Day Year
P.O.	hat th ed by detac	y Ph	Part II. Other significant conditions contributing to death but not re	esulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
S,	requires that been signed should be de	Completed by	· Lange Oscilis	1	1	1 Yes	2 No 3 P	robably 4 🗌 Unknown
oro	w require s been si should	plete	. Ace to rend	100	liere	24a. Was an	24b. Were au	topsy findings available
3ec	sician: The law certificate has rector, page 2	mo				autopsy performed 1 \(\sum \) Yes 2	death?	completion of cause of
a	ian; T		25. Was case referred to medical examiner?		26. Place of Death (Check	-	(NO) I L res	Z 🗆 NO
Ę	hysic his ce il direc	욘	1 Yes 2 No Hospital:	☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	me 5 🗌 Residence	6 Other (Spec	ify)
٥٥	ling P	ate:	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year)	28b. Time o injury	work?	8d. Describe how in	njury occurred	
Sior	ttend death stor: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	hama farm at	M 1 Yes 2 No			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 buors after death. within 24 buors after death. with a function of the functio		4 Homicide determined 28e. Place of Injury - At I building, etc. (Speci	ify)	reet, ractory, office	28f. Location (Street City or Town, St		al Route Number,
	Hospit 24 hour Funerated fill	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the best of my known 2 Medical Examiner: On the basis of examinating the control of the basis of examinating the control of the basis of examinating the control of	tion and/or inves	stigation, in my opinion, death occurred at	the time date and al-	ace and due to the	ause(s) and manner stated
	o the		only one 3 Certifying Nurse Practioner: To the best of a 29b. Signature and title of certifier	my knowledge.	29c. License number	s, and due to the dau	Date signed (Month	stated.
	- × F Ö		Ricardalatin	D	DO07100	2 290.	$\sim 2/23$	2011
	/		30. Name and address of person who corporeted cause of death (Ite	em 23a) (Type.	Print)	- T)	7/33	2017
	ns		Licardo Costo.	10	O Brown Str	eet (he	Jertown	MD 21620
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registry's Sign	ature #	ball			

Box 68760 P.O. Division of Vital Records,

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu l 🗜 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sidr d tifle of certifier 00062623 5+1 Name and address of person who completed cause of death (Item 23a) (Type, Print) LAYEEN BOLARUM, 196 TJOLU TJD LIVE, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar DHMH 17 Rev 1/2001

FREDERICE, MD 21702

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2315 1 Daniel Connell May Medical e bruas 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suishury Rehabilitation
5. Social Security Number 6. Sex lisbure Wicomico a Nursina Ctr If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Min Hours 9-21-1926 Director 254-30-8169 84 Georgia Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director is marked other than "natural", or items 23a or 28a-f s aumatic event, the Medical Examiner must be notified 1 X Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 317 S. Haven Avenue 21804 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 X Yes If Yes, Give 2 No 1943-Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 1946 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) 10 General Manager Laundry Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Marshall Connell Lois **Feutral** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Connell - Wife Salisbury, Maryland 21804 Haven Avenue, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Springhill Memory Gd : 3-1-2011 Hebron, Marylnad 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 112 Medical resulting in death) consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequ ence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has performed' Yes 2 2 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 2 Ato Other: 1 Tes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Gritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) E N'I 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins M.D. 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink, Fasure All Copies Are Legible.
Amend 29a per med cert G913 723 Ir All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day4 Medical Mills Chandler 4a. Facility Name (if not institution, give street and number) Examiner 4b City, Town, or Location of Death 4c. County of Death 540136414 MAICO If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday, **Funeral** 1 □ M 2 🛣 F Days Hours (Month, Day, Year 2-5-1926 Mary I and 218-20-6239 Director 84 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 227 Canal Park Drive, Apt. 207 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Mills M Louise 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2180128064 Riverside Drive, Susan Chandler Spengler Ext., Salisbury, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Parsons Cemetery 2-28-2011 Salisbury, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each ling. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition EAR Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin sician and burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical the attending pl IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes 2 1 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SE 58689 2/24/2011 merkon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 & Carrol Street Salishum MD 21801 Wier 10mas 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

FEB 28 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

ichard Antho	ny C	ordrey State of Maryland 1-For State Amend 4b, 28f per ME Registrar DOR, 3/2/11, LDB	Certificate		a Mental H	ygiene Reg.	. N o.	
Physic		Decedent's Name (First, Middle,Last)				2. Date of Death Month E February 26		3. Time of Death 0420 hrs
Aedical Exam	nine	Richard Anthony Cordrey 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Death	
		Route 313 at Wheatley Church Road			ldorado		Dorchester	
Funera Directo		5. Social Security Number 6. Sex 7. Ag 1 1 M 2 F	ge (In yrs. last birthday)	If Under 1 Year Months Day		_	(MM/DD/YYYY) 9. Bir Foreig 1978 Co	inMaryland untry)
áu a		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ation				10d. Inside City Limits
*	<u> </u>	Maryland Wicomico	Sharptown					1 X Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?
th the 23s or		403 Ferry Street 11. Marital Status 12. Was Deceden	4 Ever in II S 142 M	21861	enanic Origin2 / Sr	pecify Ves or No-	USA 14 Race - Amer	can Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other ma "natural", or items 23a or 28a-f sho	Funeral	1 Never Married 2 Married Armed Forces 1 Yes 2 3 Widowed 4 Divorced larges, Give Year		Yes, specify Cubar	n, Mexican, Puerto		White, etc.	hite
ours af	À D	Tor Dates:		ent's Usual Occupat most of working life			6b. Kind of Business/	Industry
21215-0036 Muld be filed within 72 hours after Mental Hygiene. Mantal Hygiene.	Completed	Elementary/Secondary (0-12) College (1-4 or 12	5+) Weld	er			Refrigerat	ion
15-(Be Co					(First, Middle, Ma Carolyn C		
212 ould be I Ment	10 8	19a. Informant's Name/Relationship (Type, Print)			et and Number or F	Rural Route Numb	er, City or Town, State	
- p # e :		Ralph A. Cordrey/Father	P. O				yland 2186	
Baltimore, permit. Pages I ar Department of Hestimportant: If ite		1 X Burial 2 Cremation 3 Removal from S	tate crematory or o	other place)				
ltim ii. Pag urtment ortant:	5	4 Donation 5 Other Specify: 21 Signaty e of Funeral Service Life See	Sharptown 22	Name and Address eller Fur			Sharptown,	Maryland
Dep Der		Exercuel & sulle	1	06 Main S	Street, E	East New	Market, MI	
Physicia /Medica		23a. art I. Enter the disease or complications that cause failure. List only one cause are ach line.		the mode of dying,	such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
Examine	-	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injurie: Due to (or as a con-						Death
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x 6876	cian/M		t time of death	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	23d. Date of deliver Month	y Day Year
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of Vital Records, g Physician: The law requirements of the this certificate has been standing the standing of	Completed by			 .		24a. Was ar autops perform 1 ✓ Yes 2	y prior to ned? death?	utopsy findings available completion of cause of es 2 No
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Physic Price of this	∄ F	1 Ves 2 No Inpat	ient 2 ER/Outpatie		ary at Work?		esidence 6 🗸 Othe	r: Scene
on of on of ath.	tion: To	1 Natural 5 Pending Feb 26, 201		· · ·	Yes 2 V No	Driver auto fi	xed object collision	on
ivisi or Att after de Direct	Certification:	2 ✔ Accident Investigation 3 Suicide 6 Could not be determined (Specify) M	Injury - At home, farm, str ajor Road / Highwa		building, etc.	28f. Location (St or Town, Sta Route 313 at W	reet and Number or R ate) /heatley Church Ro	ural Route Number, City Eldorado ad, Fork , MD
D to the Hospital within 24 hours To the Funeral	Medical C		amination and/or investig	curred at the time, d	ate and place, and n, death occurred	d due to the cause at the time, date a	(s) and manner as sta nd place, and due to the	ted ne cause(s)
H » É	2	29b Signature and title of certifier		29c. Licens			29d. Date signed (Mo	
		N-MU.	death (Here OO)	0.C.	IVI.C.		February 26, 20	
1		30. Name and address of person who completed cause of Donna M. Vincenti, MD Assistant Med		0 W. Baltimore	e Street, Baltir	more, MD 212	23	
	State istra		ar's Signature	we				

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08319 State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rose M. Cecchine M3+05-2841 0430 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Linthicum 4c. County of Death Examiner Anne Arundel Heart Homes Assisted Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day Year)

01-16-1917 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 □ M 2 💆 F Hours 94 Pennsulvania 168-30-5662 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Examinar must be notified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harkord Havre de Grace Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 United States of America 218 South Union Avenue Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🛣 No Specify: þ 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Family 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Rossi Mary Josephine Ross ည 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 4061 Historic Virginia Cowit, Dumfries, Virginia 19a. Informant's Name/Relationship (Type. Print) Gary Cecchine (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Grace Memorial Gardens 04-05.2011 Hudson, Florida 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Zellman Funeral Home, 123 S. Washington St, Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caus id the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** men disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☑ No Day Year Month 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performe certificate 1 □ Yes 1 Tyes Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) MISISTE Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident within 24 hours aft r deatl To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) 29b. Signature and title of certifie erson who completed cause of deatl (Torb at WD 31. Date filed (Month; Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Genevieve O'Leary Dane Physician/ February 2011 9:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolis Examiner 4c. County of Death Sunrise of Annapolis Assisted Living Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | Oct. 28 Social Security Number 536-01-7852 7. Age (In yrs. last birthday) **Funeral** g. Birthplace (State or Foreign ^{Year)} 1<u>917</u> 1 ☐ M 2XXF Months 93 Director Michigan Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Bestgate Road 21401 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: White Specify: 3℃Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic
once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Program Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) ൧ John O'Leary May McCorkell 19a. Informant's Name/Relationship (Type, Print)
Michele Jaklitsch/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3426 Hidden River View Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 3/2/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Funeral Sendce Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the Intensal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Horre 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 2 1 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No Hospital: 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 570a8 2-28-2011 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aditya Chopra MD 600 Ridgely Ave Suite 231 Annapolis MD 21401 31. Date filed (Month, Day, Year) 1 2011 distrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 8: 26 AM Jean Koreen Dean Medical mas 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceniversity of Maryland Medicul Crotter

Social Security Number 6. Sex 7. Ane Iln vrs. last birthd Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - F 218-34-8791 67-20^{4ea}1938 Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f sh must be notified a 1√ Yes 2 ☐ No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 67 Cutter Crossing USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Day Care Provider Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ္ Dean Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Department of Health Important: If item 27 any injury or other the <u>Andrea Dean Daughter</u> Cutter Crossing Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 03/12/2011 Emmanuel U,M. Church Page 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chestertown, MD 21620 22. Name and Address of Facility Bennie Smith Funeral Home 855 High ST Chestertown, MD 21620 a /1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ue to (or as a consequence disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 🗹 Probably 4 ☐ Unknown Fra - stage reneal disease, coronary artery disease, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an diabetes, hypertension has 2 🗆 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 M No Other: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural injury 5 Pending thin 24 hours after death.

the Funeral Director: Af
impleted filled in by the fu 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Number Practioner: To the best of my knowledge, or other productions of the time date and place and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) P24354 mar, 1, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly Norsworthy, 22 South Greens Street, Bottimore, MD 21201 31. Date filed (Month, rar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Please Type or Print in Black Indelible Ink. Ensure All Copie (7ay, Jr State of Maryland / Department of Health and Mental H (7a)	Reg.					
Physiciar dical Examin		Garry Wayne Donaway, Jr.	2. Date of Death Month D March 5, 20	ay Year	3. Time of Death 1418 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	h			
		12614 Ocean Gateway Room #44 Berlin		Worcester				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr. 217-02-4773 1 Mm 2 F 37 Yrs. Months Days Hours Mir		MM/DD/YYYY) 9. Bi Forei . 9 7 3	rthplace (State or gn Puntry) MD			
nd show any ice.		MD Wicomico Willards		,	10d. Inside City Limits 1 Yes 2 No			
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	Intry?			
3a or	盲	36766 Three Bridges Rd. 21874		USA				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f should purply or other frammatic event, the Medical Examiner must be positived at one.	Funeral	11. Marital Status 1	specify Yes or No- o Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,			
s after	≱⊦	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of			nite			
36 hin 72 hour e. than "nata edical Exar	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ret	tired)		,			
ed with	탕	12 Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name		Automobile Surname)				
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than anumatic event, the Medica	å	Garry Wayne Donaway, Sr. Frances						
Should Me mid Me mid Me	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,						
and 2 sealth a sem 27	-	Tamela Donaway / wife 36766 Three Bridge 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Willards Oc. Location - City or					
it of H		1 K Burial 2 Cremation 3 Removal from State crematory or other place)						
Baltimore, permit. Pages I ar Department of Hes Important: If ite	-	4 Donation 5 Owner Specify: Riverside Cemetery 3/ 21. Signature of Funeral Forvice Licens (22. Name and Address of Facility D.)	Berlin,	MD				
Dep		21. Signature Funeral Furvice Licens 22. Name and Address of Facility Burbage Funeral 108 William St., Berlin, MD						
Physician	1	23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final disease a. Oxycodone Intoxication			Death			
	ı	or condition resulting in death) Due to (or as a consequence of):						
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	€	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):						
- 1	ן נב	events resulting in death) Last Due to (or as a consequence of): d.						
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Box 68760, e death certificate be ex- the attending physician ed for use as the burial		F FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the		23d. Date of delivery	,			
ox 687 eath certification attending for use as t		past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna	ancy	Month [Day Year			
Box 6 e death cer the attendi	2	1 Yes 2 No 9 Unknown 9 Unknown						
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uires t n sign Id be d				No 3 Prob	pably 4 V Unknown			
ords w requi			24a. Was an autopsy	prior to c	topsy findings available completion of cause of			
tal Reco	Completed		performed 1 ✓ Yes 2		s 2 No			
cian: certifi ector,		25. Was case referred to medical examiner?						
Physical dir	의	1 Yes 2 No No No No No No No No		idence 6 🗸 Other	: Scene			
F # . ~ 4 6	<u>ۊ</u> ٳ	1 Natural 5 Pending (Month, Day, Year)	28d. Describe how					
	≅ I	Accident Investigation fd 3-5-11 fd 2:10pm Tes 2k No	ingested	pills				
Division pital or Attendio ours after death. teral Director: Affilled in by the fi	<u> </u>	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Stree	et and Number or Ru	ral Route Number, City tel 12614 Ocean City,			

State 31. Date filed (Month, Day, Year)
Registrar

29b. Signature and title of certifier

30. Name and address of person who complete cause of death (Item 23a)
Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)

March 6, 2011

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:00a M Carmelina Feb. 27, 2011 Year Romero De Guevara Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Montgomery 20309 Grazin Way Montgomery Village Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🏞 F 2/27/74949 EÎ^{oun}Salvador Director Inone 62 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 🔀 Yes 2 🗌 No Montgomery Montgomery Village 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20309 Grazin Way 20886 El Salvador or items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. White ģ 1 Never Married 2 X Married 1 Xyes 2 No El Salvadoren Maryland 21215-0036 If Yes, Give Year or Dates "natural", Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Juan Carlos Romero Carmelina Rauda 19a. Informant's Name/Relationship (Type, Print us and Roberto Antonio Guevara-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 20309 Grazin Way Montgomery Village,Md permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Gutierrez Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cemeterio
Transito 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation nsito 3/06/2011 SanMiguel ElSalvador PANDE TPADE SERVICE, P.A. neral Servic 21. Signature 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Carcinoma unknown primary Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the hurial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 🔀 No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown should peen 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has page 2 autopsy performed' death? Yes 2 X N 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 Tes ျ 4 - Nursing Home 5 - Residence 6 - Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After X Natural 5 Pending 1 🗌 Yes 2 No after death ☐ Accident Investigation Suicide within 24 hours after de
To the Funeral Directo 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Feb. 28, 2011 D42452 30. Name and address of person ho mpleted cause of death (Item 23a) (Type, Print) Chitra Rajagpoal M.D. 18111 Prince Philip Drive Olney, Md 20832 31. Date filed (Month, Day, Year) State MAR 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🕦 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February John Н. Dunne 2011 3:55a [™] Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery Social Security Number 8. Date of Birth Sept. 28, If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign Months 1 🛣 M 2 🗆 F Days Min. ear) 1928 326-20-8136 82 Country) **Director** ILUsual Residence of Decedent 28a-f show 10a. State filed within 72 hours after death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director NJ Monmouth Rumson 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 29 East River Road 07760 USA "natural", or iterr ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces
1 X Yes 2 If Yes, Give þ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Korean Year or DatesConflict Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. other than Elementary/Seconday (0-12) College (1-4 or 5+) Organizer Labor Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be John Dunne Adeline Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Colleen Fischer/Daughter 29 East River Road, Rumson, NJ 07760 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, cemetery, crematory or other place) 1² Burial 2 **⊘** Crematipn 3 ☐ R rom State 3/1/11 Silver Spring, MD 5 Qther (Specify) Gate of Heaven Cemetery 4 Donation 21. Signature of y ervi e (icen Francis J. Collins Funeral Home Inc. 100 University Blvd.W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a Enterococcal Sepsis Medical Due to (or as a consequence of Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Tes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Yes 2 K No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice
6 Other (Specify) Hospital 1 ☐ Yes 2 🔀 No Other Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4

Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Within 24 hours after death. To the Funeral Director: After 1 🖺 Natural injury work?
1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 1 Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 6+1 D60634 Feb. 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, Rockville, MD 20850 Bindu Joseph, MD 31. Date filed (Month, Day, Year, Registrar's Signature State MAR 01 Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 3:00p M Marina Borisovna Demidova 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7723 Goodfellow Way Derwood Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days (Month, Day, Year) 51 Director 218-35-0478 59 Russia Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 🗓 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7723 Goodfellow Way 20855 within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 Yes 2 X No þ Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify Completed 3 X Widowed 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5**+ Private Industry Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Galina Mikhailovna Mikhaylova Boris Yefimovich Krushkol permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lev Demidov - Son 1723 Goodfellow Way, Derwood, Maryland 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Parklawn Mem. Park 03/02/2011 | Rockville. Maryland Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, (Would 🛮 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Gliobastoma Multikorme disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 🗓 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 🗌 Yes 2 🗶 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 🗌 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D23308 February 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor M. Priego. M.D. 6420 Rockledge Drive, #4100, Bethesda, Maryland 20817 31. Date filed (Month, Day, Year) Registrar's Signat State MAR 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08326 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert D. Davis Jr Feb 23,2011 3:46p М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chevy Chase Montgomery 4620 N. Park Ave . Age (In yrs. last birthday) Social Security Numb If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 370-16-6484 1 X M 2 - F Months Days Hours Battle Creek, M. Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Chevy Chase 1 X Yes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 20815 4620 N. Park Ave 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1942 Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 1945 Completed Specify: White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working to Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Critic The Arts Theater Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ပ Lulu May Van Valin Robert D. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4620 N.Park Ave#07W Chevy Chase, MD 20815 Henry Schalizki/ Partner 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Department or Important: If any injury or Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 3-1-2011 22. Name and Address of Facility Joseph Gawler's Sons, INC Signature of Funeral Service License 5130 Wisconsin Ave, N.W. Washington DC 20016 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition Years Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Coronary Artery Disease Years Examine Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) been signed by the atte should be detached for in the past 12 months? Dav Year Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas performed? Yes 2 No death? After this certificate 1 ☐ Yes 2 ☐ No the Funeral Director: After this certifically pleted filled in by the funeral director, in 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ٥

State

Nancy Davenport, M.D. 3301 New Mexico Ave, N.W. Washington DC 20016

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

31. Date filed (Month, Day, Year)

MAR 01 20

MD 18999

Feb 25,2011

			For State RegistrapMFND#19box		Maryland / [-	ment of H		-	giene Reg. No.	Parameter of	083	27	
	Physici /Medic		1. Decedent's Name (First, Midd JOHN		DAV	VES			2. Date of De Month FEBRUAL	Day	, Year 2011	3. Time of I		
	Examin		4a. Facility Name (If not institution HOLY CROSS HOS		eer)		b. City, Town, or SILVER	r Location of Dea SPRING	th		County of Death			
المحق	Funeral Director		5. Social Security Number 216–60–0627		Age (In yrs. last bir		Under 1 Year Ionths Days	If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	9. Birth Cou	place (State or intry)	Foreign	
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3-0030 72 hours after death with the Maryland	a within 72 hours after death with the Marylan giene. Ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	tor		GOMERY	SILVE							1 □Yes	_	
	vith the	Directo	10e. Street and Number				10f. Zip Code				en of What Cou	intry?		
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20	s after ; or ite	by Fu	1 ☐ Never Married 2 ☐ Ma 3 █ Widowed 4 ☐ Divorce	Armed Force 1 Yes 2 If Yes, Give Year or Date	□ No VIETNA	AM-	Yes 2 No	Specify:	no mean, etc.)		Black, White Specify: MUL		AL	
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be filed that Hyger event,		o Be Co	17. Father's Name (First, Middle CLARENCE JOHN	<u> </u>				ame (First, Middle		Maiden Surname) SWANN				
Mary	s 1 and 2 should be f Health and Menta ttem 27 is marked other traumatic ev	Ĕ	19a. Informant's Name/Relation TAMMY PEARL DA		19t 81 .	1 - EDE	Address (Street LBUT DR blut	and Number or F	Rural Route Numb	oer, City or	Town, State, Z MD 2090	ip Code) 1		
Ç.	0 0		20a. Method of Disposition 1X Burial 2 □ Cremation	a 3 □Removal from St		of Disposition	on (Name of ory or other place		Date		cation - City or T			
	permit. Pag Department Important: I any injury conce.		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service	(Specify)	GATE O			ETERY 3			R SPRIN			
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	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C		,-								
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O. DOX	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the buria transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bir	ome pf pregnancy th 2 □ Fetal deati nt at time of death vn		ctopic pregnanc ther <i>(specify)</i> _	у		2	23d. Date of deli Month	-	Yea r	
ď,	w requires that the de been signed by the s should be detached	by Ph	Part II. Other significant cond	itions contributing to dea	th but not resulting i	in the unde	erlying cause giv	en in Part I.			se contribute to			
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ב	: The law cate has b , page 2 s	Completed							- auto	opsy formed? 2 No	prior to c	completion of ca	ause of	
V Ital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:			all pos Oth	or.	illi .	Check onl one				
5	ding Physician: n. After this certific funeral director,	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of		Time of Injury	28c. Inju	4 LI Nursing	Home 5 ☐ Res 28d. Describe			cify)		
VISION	Attending r death. ector: After by the funer	catio	3 Suicide 6 Coul	stigation	of injury - At home, for		M 1□	Yes 2□No	28f Location	(Street an	d Number or Ru	ıral Route Nun	nher	
2	pital or Al ours after d eral Direc filled in by	Certification:	4 ☐ Homicide dete	rmined building	g, etc. (Specify)	arri, orrect	i, idolory, omoo		City or To	wn, State)			
	24 hc 24 hc Fun etely	Medical (29a. Certifier 1 Certify (Check only one) 2 Medic	ying Physician: To the bas al Examiner: On the bas and manne	ge, death o	ccurred at the ti stigation, in my	ime, date and pla opinion, death o	ce, and due to the	e cause(s) e, date and	ause(s) and manner as stated. ate and place, and due to the cause(s)				
		Š	29b. Signature and title of certi	fier			29c. Licens	se number 135846			te signed (Monte			
•	10+1		30. Name and address of person	on who completed cause	of death (Item 23a)	(Type, Pri	int)							
			NATALIE M. VAS	32. Be	gistrar's Signature			EET NW,	WASHING	TUN, E	20422	./ ხგგ		
4	Sta Registi		MAR 0 2	2011	A. B.	par	10							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death mor If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State **Funeral** 1 M 2 DKF Director Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Funeral Director 1 Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 MrNo
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygenen and art. If item 27 is marked other than "natural", or any or other traumatic event, the Medical Examiny or other traumatic event, the Medical Examiny or other traumatic event, the Medical Examing or event. Baltimore, Maryland 21215-0036 1 Yes 2 Ho Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) embly Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) of Funeral Service License Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause dislase Immediate Cause (Final End Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of requires that the death certificate be executed Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 4No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h performed' 2 - No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Tes 2 100 4 Narsing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Matural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifile 29c. License number D47924 2.28. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIBGE THANWY NOMAN 503 58 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-01926 State of Maryland / Department of Health and Mental Hygiene Denise Davidson 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BAKER 0702 hrs DAUIDSON **Medical Examiner** ENISE March 11, 2011 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll 1736 Baust Church Road Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) M Months Days Hours Director 218 78 1391 2XF UNE Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No CARROLL MO BRINGE INION hours after death with the Maryland Director 10g. Citizen of What Country? CHURCH ROAD Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X No Yes WHITE 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed Specify: خ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) t. Pages 1 and 2 should be filed within 72 litnent of Health and Mental Hygiene.

rtant: If item 27 is marked other than "t or other traumatic event, the Medical E. Hygiene.
d other than ",
the Medical 1 Baltimore, MD 21215-0036 0 DENTAL ASSISTANT MAINEE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ICHARD ALLENDER SETTY 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) BAUST CHURCH RO UNION BRIDGE MO 21791 DIANA J. BAKER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 crematory or other place) WINFIELD, MO 2011 South CANWIL Crem Donation 5 Other Specify. 22. Name and Address of Facility () N Zum Brun Fit & Mon Co 21. Signature of Funeral Service Licensee ELDERSBURG MO 21784 & STRESVILLE RW rart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Multiple Drug Intoxication (Involving Oxycodone, mediate Cause (Final disease a. Meprobamate, and Amitriptyline, and Doxylamine Approximate Interva Physician Between Onset and /Medical Death xaminer or condition resulting in death) Due to (or as a consequence of): and Diphenhydramine Use Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical AMENDED 23a, pt. II, 27, 28a-f per me g913 3-18-11 vt X UNPENDED attending physician or use as the burial requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Month Fetal death Day 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ✓ Yes 2 No 3 Probably 4 Unknown **Emphysema** Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 2 No certificate **✓** Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA 1 🗸 Yes ဥ 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 X No Pending

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi

fd 3-11-11 fd 6:47am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1736 Baust Church Rd. Westminister, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined residence 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MOR O.C.M.E March 11, 2011

30. Name and address of person who completed cause of deeth (Item 23a)

NAR 16 2011

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Victor Weedn MD JD

32. Registra/s Signature

State Registra DHMH 17 Rev 1/2001

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Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sylvia Eversin 1842 PM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 09/25/1937 73 224-46-6879 Director Usual Residence of Decedent 28a-f shov 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Directo Maryland Calvert Port Republic 1 Yes 2 No 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code Funeral 20676 3557 Hill Top Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 K Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🏲 No Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Dept. of Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Louise Pearl Roy Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 3557 Hill Top Drive Port Republic MD 20070 Philip Everson - spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 03/D2.201 Pate Metropolitan Funeral Service 20c. Location - City or Town, State 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria Virginia Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Island Rd. Port Republic MD 20676 22. Name and Address of Facility Mauso 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, COPO disease or condition Medical resulting in death) Due to (or as a consequence of) **"**Examiner ToSacco Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 X Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 20061783 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ben 5 Arederick, mo zoure 1001 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2011 Registrar

For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

ible.	
11 08331	
3. Time of Death Year 011 12:10 A ^M of Death	
gomery 9. Birthplace (State or Foreign Country) Maryland	
10d. Inside City Limits 1 X Yes 2 □ No	
What Country? States	
- American Indian,	
k, White, etc. White	
siness Industry	
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)	
tate, Zip Code) MD 20852	
City or Town, State	
11s Church, VA	
DC 20012	
Approximate Interval Between Onset and Death	
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bute to the cause of death?	
3 Probably 4 Unknown	
Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No	
r (Specify)	

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14. Race

Specify.

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February 25, 2011

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DHMH 17 Rev 7/2009

State

Registrar

Aimee J.

31. Date filed (Month, Day, Year)

MAROI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's

Seidman,

D 37801

15020 Shady Grove Road, Suite 300, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For amend#5 per FH State of Maryland / Department of Health State Registrar 3/2/2011 AACO HEALTH DEPARTMENT. CMCertificate of Death 2. Date of Death 3. Time of Death Physician/ Month 2/23/2011 10:15ам James H. Edds Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Charlotte Hall 4c. County of Death St. Mary's Charlotte Hall Veterans Home 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 12 M 2 | F Hours M27771945 Country Director VA 65 Usual Residence of Decedent 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f St. Mary's Charlotte Hall 1 Yes XX No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 29449 Charlotte Hall Rd. 20622 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian "natural", or ite Black White etc \times Yes 2 \square No 1966- If Yes, Give þ 1 Never Married 2 Amarried within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 xxNo Specify: White 3 Widowed XX Divorced Completed 1977 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Boat Building USNA Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve William Edds should be Myrtle Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is 63 Church Rd. Arnold, MD 21012 Jennifer Edds Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/28/2011 Crownsville, MD Maryland Veterans Cem 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner eumonia Sequentially list conditions Examiner if any leading to immedicause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the af d be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr Division of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directorial d Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 2 🗆 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature Regis State

Registrar
DHMH 17 Rev 7/2009

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\(\begin{align*} \text{ \text{Mental Hygiene}} \\ \text{ \text{ \text{Polymer}}} \\ \text{ \text{ \text{Polymer}}} \\ \text{ \text{Polymer}} \\ \text{Polymer} \\ \text 1 - State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 7:15 A Thomas Edward Fleming, Jr. February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 529 Norton Lane Arnold If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours Min 1 🛛 M 2 🗆 F Yrs Director Tuly 08,1950 Ohio 298-48-8887 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location **Funeral Director** MD Anne Arundel Arnold 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? with the USA 21012 529 Norton Lane within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify. White 3 🗌 Widowed 4 🗎 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Law Enforcement U.S. Capitol Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental tant; If item 27 is marked o ပ Dorothy Lucille Rubenstahl Thomas Edward Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold, MD 21012 529 Norton Lane Phyllis L. Fleming / Wife item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important; If it
any injury or o ☐ Burial 2 【**Cremation 3 ☐ Removal from State February Baltimore, MD Metro Crematory, INC. 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Lice 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between art 1. Inter the disease, or co shock, o heart failure. List on Onset and Death mmediate ause (Final disease or ondition resulting in death) Physician/ years Amyotrophic Lateral Sclerosis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached for Pregnant at time of death the Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by the pet det <u>چ</u> Records, 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? 2 🗌 No Yes 2 💢 No 1 Tyes Division of Vital or Attending Physician: ours after death. eral Director, After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 XNo မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completed filled ir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination investigation, it may specified at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 01, 2011 D36668 120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18 Lee Goodman Green Street Annapolis, MD 21401 31. Date filed (Month, Pay Year) 2011 Registrar's Signature State backe Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08334 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month acqueline Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number Date of D. (Month, Day, 23 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Months 223-30-2023 84 Virginia Director Usual Residence of Decedent be filed within 12 more. Sents I Hygiene. Sant arked other than "natural", or items 23a or 28a-1 snormared other than "natural", or items 23a or 28a or 28a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 362 Oak Drive 21012 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irene Hardiman Harry Lee Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5612 Silo Hill Court Derwood, MD 20855 Patrick Sieg / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State February 28 Metro Crematory, Baltimore, MD 4 Donation 5 Other (Specify) INC 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, 21146 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ tod Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L. Feta Col.
Pregnant at time of death Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? by Records, The law requires Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an page 2 s autopsy Hospital or Attending Physician: Be completed filled in by the funeral director, Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending iniury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 Medical Parkney Sate 210 . Registrar's Signa State Registrar

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Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney for State Registrar 08335 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Dennis Kirk Fitzgerald Medical <u>February</u> 3:00 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Spring If Under 24 Hrs. Montgomery Social Security Number 8. Date of Birth (Month, Day, Year)
May 15, 1950 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 9. Birthplace (State or Foreign 1 XM 2 D F Hours Months Days Country) **Director** 60 Yrs May 505-62-0549 Usual Residence of Deceden 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. 1 Yes 2X No Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6908 100th Avenue 20706 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates. 1 Yes 2 1 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working 2 should be filed within 72. In and Mental Hygiene. To is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Computer Scientist Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Don Casot Fitzgerald other traumatic Jean Margaret Crose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st nt of Health a :: If item 27 is Nancy A. Fitzgerald/Wife 6908 100th Avenue, Seabrook, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 3/1/11 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, 21. Signature of Funeral Service Licensee francis descriptions Funeral Home Inc. \$00 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cholangiocarcinoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hyponatremia Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and Il-transit Hypotension that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical Acute Renal Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital. Other: 1 Yes 2 No ဨ 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide To the Hospital or Attending injury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: After din by the furnishment. Investigation within 24 hours after de:
To the Funeral Director
Acompleted filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) shan D60826 Feb. 27, 2011

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kshama Garg, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death February 28,201 gar 10:00 A M Physician/ FITCH ROBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Germantown 18462 Crownsgate Circle 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Months Jan. 21 Year 944 Wastington D.C. 1 💢 M 2 🗆 F 67 213-44-3979 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Germantown Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20874 United States Funeral 18462 Crownsgate Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes Give Year or Dates. Vietnam 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Computers Electronics Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Hastings Charles Fitch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Germantown, MD 20874 18462 Crownsgate Circle Judy Miller (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place Feb. 27, 1 Burial 2 X Cremation 3 Removal from State Alexandria, VA Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilityDeVol Funeral Home entes 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury 置 The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial-t attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 5 Other (specify) signed by the and be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \) Residence \(6 \) Other (Specify) Hospital: 1 ☐ Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 X Natural 5 Pending Investigation Accident
Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c, License numbe of certifie February 27, 2011 D0035045

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

18109 Prince Philip Drive #200

Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Philip Henjum M.D.

31. Date filed (Month, Day, Year)

MARU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FEBRUARY Physician/ 7:50A JOHN PETER FISCHER Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Nov 23 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Days Hours Min 1 🖾 M 2 🗆 Months 82 Maryland 1928 212-26-4213 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director Thurmont Frederick 1X Yes 2 □ No Maryland 10g. Citizen of What Country? 10f. Zip Code or 10e Street and Number Examiner must be USA 21788 23a Funeral 105 Orchard Drive items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 0 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify white Yes Give 3 → Widowed 4 □ Divorced "natural" Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than any injury or other trainmasis. College (1-4 or 5+) Elementary/Seconday (0-12) Brick Company Supervisor 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ann Schneider John I. Fischer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beverly Nunemaker - daughter 105 Orchard Drive, Thurmont, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lewistown, Maryland 2-25-2011 Mt. Prospect Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 21704 1621 Opossumtown Pike, Frederick, Maryland Colam 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s this certificate has 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifications and preserved the second preserved t 25. Was case referred to medical examiner?

1 \sum Yes 2 \sum No 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number

0 0 0 6 2223 29d. Date signed (Month, Day, Year) 29b. Signati 2 22 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAYEEN BOLANWY, TO 196 TO DUVE, FLEDELICE, MI 21702 31. Date filed (Month, Day, Year) FEB 2 5 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 08338 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Friedel Marion A. 1:45 P February 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner Center 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Heritage Harbour Health & Rehab. Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)District of Columbia 8. Date of Birth **Funeral** 1 □ M 2 💢 F Months Days Hours Min. (Month, Day, Year) Director 577-01-8310 92 Tuly Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 🗆 Yes 2 😾 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 341 Long Meadow Way 21012 USA should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items: 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes Give White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Telephone Elementary/Seconday (0-12) College (1-4 or 5+) Communications Switchboard Operator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Kelly Ida Elizabeth Howard permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 341 Long Meadow Way Arnold, MD 21012 John Edward Friedel, Jr./ 20a. Method of Disposition February 25 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2011 Crownsville, MD Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1 Enter the essease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician diac Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 1 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation. in my opinion, death occurred at the discovered at Hospital Medical 29a. Certifier npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and of certifier 29d. Date/signed (Month, Day, Year) Ste 23 f person who completed cause of death (Item 23a) (Type, Print) HOPK C 31. Date filed (Month, Dav. Year) 32. Registrar's Signature State FEB 2 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ EDINARD MARUH 2011 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death CHESAPEAKE HUSPITAL BELAI 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** Dec 30 Days Director 315-24-4945 82 Yrs. KY Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No MD Harford Joppa 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 Garnet Rd. 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Completed Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) State Government Computer Analyst Be permit. Page 1 and 2 should be filed Department of Health and Mental Important: If item 27 is many injury or other sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Claud E. Grant Elsie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Grant/ Wife 408 Garnet Rd. Joppa, MD 21085 20a. Method of Disposition
1
Burial 2
Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/3/2011 Foard Funeral Home, P.A. 4 Donation 5 Other (Specify) Rising Sun, MD 21. Signature of Funeral Service License R.T. Foard Funeral Home, P.A. 111 S. Queen St. Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Friysician/ FPSI disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit umonia that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s performed; 2 X No Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) M80035, examiner? Other: Certificate: To 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? Natural 28h Time of 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be within 24 hours after de To the Funeral Director completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier The desired in the least of the only one) 29b. Signature and title of certifier 00589 anisma MI 2011 500 UPPER CHESA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD BAHL MANISHA 31. Date filed (Month, Day, Year 32. Registrar's Signature State MAR 03 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08340 State of Maryland / Department of Health and Mental Hygiene (For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1 Decedent's Name (First, Middle, Last) 1 Day 2011 Physician/ 9:50р м March Carolyn Lee Goodie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Port Deposit 105 Nantuckett Dr. 8. Date of Birth
(Month, Day, Year)
Sept 8, 1937 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 1 🗆 M 2 😾 F Months Days Hours 73 236-54-6406 Director Usual Residence of Decedent Show 10d. Inside City Limits 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 🗌 Yes 2 💢 No Port Deposit MD Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21904 105 Nantuckett Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XIo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Medical Records Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lola Pierce Quesenberry Arthur Bronson Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8627 Hollowbrook Way Manassas, VA 20110 Howard Goodie / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. John's Cemetery 3/5/2011 Lewisville, PA 2. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St. Rising Sun, MD 21911 Eignature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final encol yens Physician/ disease or condition Medical resulting in death) Due to as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 use as t attending IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 month 1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 2 No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ this 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined

Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of

Registrar

Medical

31. Date filed (*Month, Day, Year*) **NAR 0 3 2011** State

29a. Certifier

only one)

3

29b. Signature and title of certifier

Stemmers Run TD, Balto, 2122 JUD UDDAY 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please 1	Type or Print in Black Indelible Ink. Er	nsure All Copies Are Legib	leo n	1 1	1831	ļ
	State of Maryland / Department of Healt	th and Mental Hygiene	201	1	7004	ı

		1- For State Registrar		Cer	tificate of	Death			R	eg. No.		
Physicia Medical Exami		Decedent's Name (First, Midd	CHARL	ES GURT	Z			2. Date of Death Month Day Year February 23, 2011 3. Time of Death 1230 hrs				
		4a. Facility Name (if not institution 15902 Somerville Dri			4b. City, Town, or Location of Death Rockville				rebluary a	4c. County of D	eath	
		5. Social Security Number		a (la ura la	at high days)		r If Unde	r 24Hrs	P. Data of Bir	•	Birthplace (State or	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 21.6-1.9-0538 1 X M 2 F 36 Yrs.						Months Days		Adio			preign	
٨		Usual Residence of Decedent 10a. State 10b. County		40a City	Town or Locatio						10d, Inside City Limits	
OW Any			gomery								1 Yes 2 No	
Maryland 28a-f show	용	Maryland Montg	gomery	Gai	thersbu	10f. Zip Code			11	0g. Citizen of W hat (
ith the Maryland 23a or 28a-f sho notified at once	Dire	7204 Cliff Pir	ne Drive			2087	9			U.S.A		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. team 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	unera	11. Marital Status 1 X Never Married 2 N	12. Was Decedent Armed Forces? 1 Yes 2			Decedent of His , specify Cuban	panic Origi , Mexican,	in? (Spec Puerto Ri	cify Yes or No ican, etc.)	- 14. Race - Ar White, et	merican Indian, Black, c.	
after c	by F		vorced If Yes, Give Year		1 🗆 🕥	es 2 X No	specify:			Specify:	White	
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5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)										
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Bec	Dennis Michael	•							te Spring		
213 ould b i Men	P	19a. Informant's Name/Relations	A Committee of the Comm	===	19b. Mailing	Address (Stree				nber, City or Town, S	tate, Zip Code)	
MD d 2 sho		Harry Charles	Spring / Unc				_			town, MD		
Baltimore, MD 21215-00 pernit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other Injury or other traumatic event, the M.	Ш	20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from Sta		lace of Dispositi ematory or othe		netery,		Date	20c. Location - City	y or Town, State	
Baltimore, permit. Pages 1 at Department of He Important: If ite		4 Donation 5 Other S			thsburg		ory	2/26	/2011	Smithsbu	rg, Maryland	
Salt ermit. Peparti mport		21. Signature of Funeral Service	Licensee		22. Na ROB	ne and Address ERT E.	of Facility	Y &	SON FU	NERAL HOM	ES. P.A.	
	4	23a. Vart I. Enter the disease, or	complications that caused	the death I	1.20	J. NORTH	MARK	ET S	TREET.	FREDERIC	MD 21701 Approximate Interval	
Physician /Medical		failure. List only one cause	on each line.	the death.	DO NOT GITTER THE	mode of dying,	suci as ca	i diac or re	sopilatory arre	sst, shock, of fieldit	Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a conse	equence of)	:						Death	
		Sequentially list conditions,	b									
	miner	if any, leading to immediate Due to (or as a consequence of):										
	Eam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							-			
	Exa		d									
	/Medical	UNPENDED	AMENDED									
		IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcom	ne of pregna			Ectopic			23d. Date of deliv		
OX 68° sath certificate as for use as	cia	past 12 months?	4 Pregnant at	time of dea	- =	death 3 [r (Specify)	Ectopic	pregnanc	у	Month	Day Year	
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funoral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as												
To the Howithin 24 h To the Fur	edical		miner: On the basis of exam and manner stated.	nination and	d/or investigation	n, in my opinion,	death occ	urred at th	ne time, date a	and place, and due to	the cause(s)	
HSHÖ	ž	29b. Signature and title of certifie				29c. License	number			29d. Date signed (i		
		Sancte Pres	hall, mi			O.C.N	Λ.E.			February 24, 2	2011	
0	Ī	30. Name and address of person		•	,		0.	- ···				
		Pamela E. Southall, M				V. Baltimore	Street,	Baltimo	ore, MD 21	223		
Sta Regist		31. Date filed (Month, Day, Year)	1 2011 32. Registrar	's Signature	1. /	Mal						
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		State Registrar				•	artment of F <i>rtificate of I</i>				Reg. N	CULL	08342
		Decedent's Name	e (First, Middle, La	st)						2. Date of De	ath	Day Year	3. Time of Death
Physician /Medical Examiner		Patrick	William (Grimes, Sr.						Februa		18, 2011	7:00 P M
		,	, 0	e street and number)		4b. City, Town, or Location of					4	c. County of Deat Frederic	
		233 13t 5. Social Security N	h Avenue	ev 7 Age	(In yrs. last bi	irthday)	Brusnwi If Under 1 Year	. C.K. If Under	r 24 Hrs. 1	8. Date of Bit	rth	9. Birt	
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eath v	Funeral	11. Marital Status	II Avenue	12. Was Decedent E	ver in U.S.	13. \			rigin? (Sp	ecifv Yes or No		14. Race - Ame	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 25, 2011 2030 Dorothea R. Gatchell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cecil Elkton 24 Oak Hill Lane Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Year) 926 1 M 2 X F 217-20-8695 84 Yrs. Director Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Elkton 1 ☐ Yes 2 🄀 No Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r 21921 U.S.A. 24 Oak Hill Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Aberdeen Proving Ground (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary in Personnel Aberdeen, Maryland Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental Hr tant: If item 27 is marked oth jury or other traumatic even 2 Edith M. Bryson Albert E. Janes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21901 Gail S. Grace (daughter) 202 West Cecil Avenue, North East, Maryland 20a. Method of Disposition

14☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State etery, crematory or other place) North East permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) 03/03/11 North East, Maryland Comet 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ one disease or condition Medical resulting in death) Due to (or a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 4 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 2 🔀 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 💢 No Certificate: To 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

02

32. Registrar's Signature

Madai Chardon-Borrero, M.D., 7845 Oakwood Road, Glen Burnie, Maryland 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DARLENE LYNN GARDINER PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Charles Medica La Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min 3 -8 - 19 68 MD ountry) 220-86-7264 42 Director Usual Residence of Decedent 10a. State 10b County 10d. Inside City Limits or 28a-f shov 10c, City, Town or Location Examiner must be notified at Funeral Director CHARLES LA PLATA MD. Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6755 GLEN ALBIN ROAD 20646 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ō þ 1 Never Married 2 XMarried Specify: WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) GEORGETOWN UNIV. Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE HOSPITAL 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve ante. and Mental § is marked o CARNELL LEE STINNETT EARL VON FLOYD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT C. GARDINER, JR. - SPOUSE 6755 GLEN ALBIN RD. LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State HERITAGE MEM. CEM. 3-11-11 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Juneral Service Licen RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ca disease or condition Medical resulting in death) . Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Dus to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknowh Month Day Year 5 Other (specify) signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerforme death? 1 ☐ Yes 2 ☐ No 2 X N Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pendina within 24 hours are:
To the Funeral Director: Aff 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) person who completed cause of death (Item 23a) (Type, Print) Street Svite B La Plata MD 20646 entennia filed (Month, Day, Year) State Registrar

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			For State Registrar	Otate of W	iai yiai ia		tificate of l			Reg. No.	MCC(IN)	08345	
			Decedent's Name (First, Middle, L.)	ast)					2. Date of Dea	ith		3. Time of Death	
	Physicia Medio			John G. G	ergen				Februa	ry 22, 2	Year 2011	10:00рм	
	Examin		4a. Facility Name (if not institution, gi					r Location of Death		4c. County			
-	-		5500 Friendshi 5. Social Security Number 6,		1909	t hirthdayl	If Under 1 Year	thevy Char If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign	
Funeral Director 5. Social Security Number 103-40-1396 6. Sex 1 M 2 F 7. Age (In yrs. last birthd) 77 Yrs.							Months Days	Hours Min.	Month, Day June 20) 1933	Goun:	Romania	
	, MC		Usual Residence of Decedent						1 June et				
	iryland a-f sh ied at	ctor	10a. State 10b. County		10c. City,	Town or Loc		Chevy Cha	1.0			0d. Inside City Limits 1 Yes 2 □ No	
	or 28	Dire	Maryland Montgo	mery			10f. Zip Code	chevy cha		10g. Citizen of W	hat Cour		
	I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If men 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	5500 Friendship	Blud., #1	909			20815			u.s.	A.	
	death items		11. Marital Status	12. Was Decedent B	Ever in U.S.	13. V	Vas Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ	an Indian,	
36	after al", or xamii	Completed by	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		☐ Yes 2 💆 No			Specify:		hite	
Maryland 21215-0036	hours natura ical E	lete	15. Decedent's	Education	Year or Dates. Education 16a, Decedent					16b. Kind of Bu	Sb. Kind of Business Industry		
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ary	should be file and Mental H is marked o raumatic eve	72	19a. Informant's Name/Relationship				g Address (Street		er, City or Town, State, Zip Code)				
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altimore,	ge 1 ar nt of H∉ : Ifite n or oth		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3	☐ Removal from State	, cen	netery, crem	sition (Name of natory or other place	ce)	Date	20c. Location -	•		
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of	or Attending Physician: The law requires and clearth cath. Director, After this certificate has been sign in by the funeral director, page 2 should be		27. Manner of Death 1 1	28a. Date of inju (Month, Da	ıry 28	8b. Time of injury	28c. Injur work	y at		ow injury occurre			
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Division of Vital Records,	lor At after d Direction by		4 Homicide determine			e, farm, stre	et, factory, office		28f. Location (Si City or Towl	treet and Number n, State)	r or Rural	Route Number,	
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	To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di	Mec	only one) 3 Certifying Nu	miner: On the basis of e urse Practioner: To the	best of my ki	nd/or invest nowledge, d	eath occurred at th	e time, date and place	ce, and due to the	cause(s) and mar	nner as sta	ated.	
	2 × 2 × 2		29b. Signature and title of certifier	n A	NÁ.		29c. Licens		2	29d. Date signed			
	•		30. Name and address of person who	completed cause of d	leath (Item 2)	3a) (Type P	rint)	D39456		Februar	y 24	, 2011	
			Lila McConnell	2, M.D., 55	30 Wi	scons.		2, #1400,	Chevy c	chase, M	aryli	and 20815	
	Stat	te	31. Date filed (Month, Day, Year)	32 Registra	ar's Signatur		Med						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 00:300 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death . County of Death Seasons Hospice Randallstown Baltimore . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, 1 ☐ M 2 🖾 F Days Hours 80 New Jersev Director 151-26-5318 1930 Oct. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 United States 100 Burgess Hill Way, Apt. 302 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify: White 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Δ Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henrika Holthuson Bernard Key 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, $327\ South\ Church\ St.,\ Middletown,\ MD\ 21769$ Heather Smolinski / Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February 24, 1 Burial 2 Kremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Crematory Frederick, Maryland 20I1 21. Signature of Funer 12 ryice Linesee Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part I. Enter the disease, or subcle, or heart allure. List of Immediate Cause (Final disease or condition resulting in death) Approximate Onset and Death Physician Esuphageal lancer netastatic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Yes 2 No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hospital or Attending Physician; The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 2 🗌 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 1 Other (Specify) Hospital Other: 1 🔲 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

NSKY Washe M) 29c. License number 29d. Date signed (Month, Day, Year) 00057465

Registrar DHMH 17 Rev 7/2009

State

2835 SMITHAN

32. Registrar's Signature

203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, MID

FEB 2

31. Date filed (Month, Day, Year)

2/22/11

Baltimore, MD. 2120 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 01:59 PM Audrey Hanbury Goolsby February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Virginia 1 M 2 X Days Hours 124/1925 579-26-8256 85 **Director** Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 2644 Quiet Water Cove Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ori 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", Completed 3 ♥ Widowed 4 □ Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Department of Defense Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill tment of Health and Mental rtant; If item 27 is marked o Audrey Bernice Griffin Lewis Franklin Hanbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 538 Coover Road, Annapolis, Maryland 21401 Susan G. Stevens/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 2/28/11 Crownsville, MD 21. Signatur A Fineral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) ter othera Medical Due to (or as a consequence of) Examiner 1400 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury Due to (or as aconsequence of) that initiated events resulting in death) Last and physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed' certificate 1 Yes 2 1 25. Was case referred to medica director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Latural 5 Pending 1 ☐ Yes 2 ☐ No vwithin 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2/23/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ Lillian Luvenia Gallagher 2011 11:05 PM Medical 4c. County of Death
Anne Arundel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) Sept. 15, Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. 212-26-0878 1 ☐ M 2XX 82 Months Days Hours Maryland 1928 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 28a-f sho 10a, State filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director Maryland Anne Arundel Annapolis 1**XX**Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 92 Summerfield Drive 21403 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status ð 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3XXWidowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o Leonard Basiliere Luvenia Chaney 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Mason/daughter 92 Summerfield Drive Annapolis, Maryland 21403 20a. Method of Disposition 20c. Location - City or Town, State 20b, Place of Disposition (Name of Date cemetery, crematory or other place) 9 1

✓ Burial 2

Cremation 3

Removal from State permit. Page Department of Important: If any injury or once, 2/28/2011 akemont Mem. Gardens Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu neral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Liter University Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director; After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 ☐ Unkno√n 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🕽 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) 25 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month, 32. Registrar's Signature State FEB 282011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mar 10, 2011 Physician/ 4:10 AM Golliday Franklin Henry Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Allegany Cumberland Devlin Manor Nursing Home If Under 1 Year | If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Country) VA **Funeral** Hours Jul 24 235-28-3583 89 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 12905 Golliday Lane NE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No If Yes, Give WW II Specify. white 3 XWidowed 4 Divorced Completed Year or Dates o Mental Hygiene. In arked other than "natura mati⊨ event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bauer Garden Center salesman and Mental Hygie is n arked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is narried any injury or other traumfath evo ည Mary (Spiggle) Golliday Homer Golliday ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 12914 Golliday Lane NE Cumberland 19a. Informant's Name/Relationship (Type, Print) MD 21502 James Golliday son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Restlawn Memorial Gardens ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/2011 MD LaVale 4 Donation 5 Other (Specify) Signature f Funeral Se 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par/1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) ng physician as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 DNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1-Natural work 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) March 10, 2011 00017565 son who completed cause of death (Item 23a) (Type, Print) 922 Net'1 11TOL Belline MD 770 31. Date filed (Month, Day, Year, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Tracy Denise Hylton \mathbf{g}^{M} 2011 9:56 Feb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7843 Lakeshore Drive Calvert Owings Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Min. (Month, Day, Year) 1 □ M 2 🛛 F 47 **Director** 219-86-2938 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Martinal Example. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 ☐ No Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7843 Lakeshore Drive USA <u> 20736</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify. Specify: White 3 - Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Jackie Huscusson Benjamin Earl Hylton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Thrift/Next of Kin 7843 Lakeshore Dr., Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mem'l Gardens 3/4/11 4 ☐ Donation 5 ☐ Other (Specify) Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond-Wood F.H., Box 430, PO Dunkirk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ADENDIARGILIDINA OF LUNG-WELTELD M Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 25 No
9 Unknown Pregnant at time of death sate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 00 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature 32. Registra Signature

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-- State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Edward Hoover Hagelin, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Burnett-Calvert Hospice House PrinceFrederick c edver If Under 1 Year If Under 24 Hrs Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 03-20-1929 1 **X** M 2 □ F 215-26-0392 81 **Director** Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Maryland Calvert Lusby 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20657 United States 50 Appeal Lane, Apt. 114 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 No. 1 Yes, Give 1948 Year or Dates. 1956 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Residential and Elementary/Seconday (0-12) College (1-4 or 5+) 8th Commercial Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sara Mae McClain George Washington Hagelin, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1470 Cedar Lane, Lusby, Maryland 20657 19a. Informant's Name/Relationship (Type, Print) Edward H. Hagelin, Jr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Middleham Chapel Cemi. 03-03-2011 Lusby, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ concer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Accessive within 24 hours after death.

To the Funeral Director, After this certificate for the Funeral director, pag perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other:
4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Acertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) (ILLING CROP) 12134730 9-91-9011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tincetrederick MD 20078 Titlany Gaines, CRUP 238Merrimac 31. Date filed (Month, Day, Year) 32. Registrar Signature

DHMH 17 Rev 7/2009

Registrar

MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HOKE Month Physician/ John 11:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bethesda Health & Rehabilitation Cnt Bethesda Montgomery If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 925 Pennsylvania 080-18 2366 85 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ms 23a or must be r Funeral U.S.A. 5421 Waneta Road 20816 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 12. Was Decedent Ever in U.S. 1. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Menta Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married Married by 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Biologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Helen Lamb John Lindsay Hoke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5421 Waneta Road, Bethesda, MD 20816 Sylvia H.Hoke/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Feb. 26, 2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitan Crematory 21. Signature of Juneral Service 22. Name and Address of Facility DeVol Funeral Home MO1315 2222 Wisconsin AVe., N.W. Washington, D.C.20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final neumonia Ph sician/ disease or condition Medical resulting in death) Due to (or as a pasequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of a: attending physician and for use as the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown certificate has been signed by the rirector, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner'i Hospital 입 1 🗌 Yes After this c 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury a Certificate: 28d. Describe how injury occurred injury To the Hospital or Attending
within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Milagritos J.

31. Date filed (Month, Day, Year)

Harding-Omar

Grosvenor Lane, Bethesda, MD 20814

5721

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02/22/2011 GERALD CARLOS HINES M 2235 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 02/07/1932 IL Country) 1 🛛 M 2 🗆 F Days Hours Min. Director 345-24-5902 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🗆 No VA Prince William Dumfries 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funera 17296 Wexford Loop 22026 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1954δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced Completed 1956 Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ray Hines Ruth Woodruff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna R. Hines/daughter 17296 Wexford Loop, Dumfries, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 02/25/11 Cremation Sv Hanover, MD 21. Signature Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complica shock, or heart failure. List inly one c complication that caused the deal o not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner hymuno deficiency Syn Nome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed attending physician a to for use as the burial-true that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death ned by the a detached to g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ be 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 2 🗆 No this certificate Yes 2 1 1 Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Seath Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, Year) 1 Natural
2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0060100 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD 51 Sust 31. Date filed (Month, Day, Year) State MAR Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death **Physician** Month Year 11:34pm Hazel Vermal Green February 21. 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner #310 Prince George's 3001 Queens Chapel Road. Mount Rainier 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Hours Min. 1 □ M 2 🗓 F Days Director 578-22-8977 North Carolina 10/26/1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Nextern Examinar member to notified and 1 X Yes 2 □ No Director Prince George's Mount Rainier Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3001 Queens Chapel Road, #310 20712 u.s.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify. Specify: African-American ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be i 2 should be fill the and Mental Fill is marked other in the standard in the 2 Jacob Smith, Jr. Bertha Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Department of Health a Important: If item 27 is any Injury or other tra once. Peggy Miles - Daughter 2407 Lyndon Street, Hyattsville, Maryland 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/27/2011 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. $\bigcirc \sim$ a |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed buriai-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Day 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate performe 1 □ Yes 2 XNo 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Certification: To 1 Yes 2 **X**(No Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. ecify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifie 1 Certifying Physician: to the best of my 2 Medical Examiner: On the basis of examiner and manner stated. knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) To the I within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD034861 February 25. 2011 address of person who completed cause of death (Nem 23a) (Type, Print) Tahmoures Dehesh, M.D., 1150 Varnum Street, NE, Washington, DC 20017 31. Date filed (Month, Day, Year) 32, Registrar's Signature State MAR 01 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Day 26 201 022/AM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ALLES NUrsing Somerset Cris field, 7. Age (In vrs. last birthday) If Under 1 Year 8106 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Princess Anne Somerse Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. A 30588 21853 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Captain's galley Laborer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosalez Norfleet Richard Harri'S 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rolley Circle Princess Anne, MD 21853 Annie Skipjack 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hopewell, MD, Hopewell van.c. Cometery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anthony E 21. Signatura of Funeral Service Licensee 30639 Hampden Ave, Princess Anne, MD, 21853 E - W/4

Physician /Medical

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce.

Physician

/Medical

Examiner

Funeral

Director

than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at

Director

þ

Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

physician and s the burial-tran

Examine requires that the death certificate be executed Physician/Medical Be Completed by To the Hospital or Attending Physician: Medical Certification: To within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera

Division or Vital Records, P.O. Box 68760

23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. Do not enter the one cause on each line.	mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between Onset and Death					
Immediate Cause (Final disease or condition	a CEREBROVASULL	Chockana Boan.							
resulting in death)	Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b								
Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		pic pregnancy or (specify)		23d. Date of delivery Month Day Year					
Part II. Other significant conditions of	ontributing to death but not resulting in the underly	ing cause given in Part I.		ouse contribute to the cause of death? 2 No 3 □ Probably 4 □Unknown					
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ► No					
25. Was case referred to medical		26. Place of Death	(Check only one)						
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3[DOA Other: 4 Nursing Hor	ne 5 🗆 Residence	6 ☐Other (Specify)					
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work?	28d. Describe how inj	jury occurred					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	and Number or Rural Route Number, te)						
	visician: To the best of my knowledge, death occi niner: On the basis of examination and/or investig and manner stated.								
29b. Signature and title of certifier	satyal MD	29c. License number D 62172	29d. C	Date signed (Month, Day, Year)					

POLOMOKE CITY

2/26/11

21851

MD

State Registrar 1604 MARKET ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARAI) R SATYAL, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Yuhwa Huang 0205 02/24/2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛣 12/05/1950 Taiwan **Director** 60 220-29-4811 Usual Residence of Deceden Pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Completed by Funeral Director 1 X Yes 2 □ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 McCormick Court 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married ☐ Yes 2 🛛 No 72 hours after Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Montgomery County Elementary/Seconday (0-12) should be filed within and Mental Hygiene. College (1-4 or 5+) Caferteria Worker Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) T.C. Huang C. Chang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chi-Yu Liang/husband 6 McCormick Court, Rockville, MD 20850 Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Sv 102/25/11 Hanover, MD 21. Signature Fi neral Service Licensed 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau o not enter the mode of dying, such as cardiac or respiratory arrest, or complications Approximate Interval Between Onset and Death 7 mon th 9 e on each line Immediate Cause (Final Ph sician/ cancer disease or condition resulting in death) Medical Due to (or as sequence of): Examiner 7 months metas tasi Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (r as a consequence of metas To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjur that initiated events physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown is certificate has been signed by the a director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) ၉ 1 Yes 2' No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director: 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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24

FEBRUARY

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

6000

3. Registrar's Signature

MERY

31. Date filed (Month, Day, Year)

MAR 02

00059244

Executive Blud Suite 302

2-24-11

Rockville, HD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:00 A ELAINE ZEPP HOWES FEBRUARY 24, 2011 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 639 LAKEVIEW DR. HOWARD MOUNT AIRY Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 5 19 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗷 F 213-42-6889 88 Mar<u>yland</u> Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Howard Mount Airy Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21771 United States 639 Lakeview Drive 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ White 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done do life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 Is marked ott Smith Arthur Inez Zepp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5837 Wild Orange Gate, Clarksville, Md. 21029 Kimberly Hiban/Granddaughter or other 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. 3/1/2011 Etchison, Maryland Mt. Tabor Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Muriel H. Barber Funeral Home m-00470 P. O. Box 5038, Laytonsville, Md. 20882 Approximate Interval Between Onset and Death 23a. Pwr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer 7 months /Medical Due to (or as a consequence of): Examiner 7 years Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit 7 years Congestive Heart Failure been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical 15 years Coronary Artery Disease 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Hyperlipedemia, Osteoposis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No this certificate 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 A Natural 1 ☐ Yes 2 ☐ No death. Il Director: A investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 decirifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 0034682 February 24, 2011 Icare Janned M.n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

State Registrar 31. Date filed (Month, Day, Year) 32. FEB 28 2011

Joanne L. Kinney, M.D.,

, 9701 New Church St., Damascus, MD 20872

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month DOITAM February Rodney Paul Hurley 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cambridge Hospital Dorchester Dorchester General If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, May 18, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F May 214-36-6187 71 1939 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD Dorchester Cambridge 1 ☐ Yes 2 👿 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3206 Indian Bone Road 21613 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; If Item 27 is marked other the any Injury or other traumatic event, Inspine. maintenance superintendent state hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lofton Elwood Hurley Mary S. Lowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth Hurley wife 3206 Indian Bone Rd., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bucktown Churchyard 2/26/11 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ischemic Cardionyspan Immediate Cause (Final End Stace **Physician** disease or condition resulting in death) /Medical Examiner Cordio valcular decare rterrosclentic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 24 No 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient After this funeral dir 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director;
completely filled in by the

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

NOMAN

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THANWY

503

2. Registrar's Signature

BYRN

29c. License number

1) 4792 4

ST CAMBRIDGE

29d. Date signed (Month, Day, Year)

2.25.2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Hazel Doreen Hill 0907 0.3 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Carroll 4b. City, Town, or Location of Death **Examiner** Westminster Carroll Hospital Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Months Days Country) Mary Land 1 🗆 M 2 💢 i Hours Min. (Month, Day, Year, 82 Director 213-24-5715 04 1928 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No New Windsor MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 500 Main Street 21776 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates ☐ Yes 2 🕅 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lena Lehr Hill Marshall E. Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Bealls Lane Frostburg, MD 21532 <u> Alice Jenkins</u> sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 03-11-2011 Frostburg, MD Frostburg Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. moa547 60 W. Main St. IGA Frostburg. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician EUKEMIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or iinjury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial by Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No this certificate has page 2 death? Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After thi leted filled in by the funeral. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1-Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. only one) 29b. Signature and title of contifie 29d, Date signed (Month, Day, Year) 2011 NO059552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POULE ROLLESTMINSTER OURI SHANKAR MAGANNA 0 TOOA

DHMH 17 Rev 7/2009

State Registrar 31, Date filed (Month, Day, Year)
NAR 1 6 2011

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Registrar

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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f she marked other than "natural", or items 20a or 28a-f she Tr. Co.		nant's Name/Relations	ship (Type, Print)			Address (Stre	eet and Num	ber or Rural Route N	umber, City or Town,	, State, Zip Code)	
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Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr	21. Signati	ure of Funeral Service	Licensee	ensee			ss of Facility	Sewell	Funeral	Home, P.A. Fred., MD	
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Box 68760, e death certificate be the attending physic ed for use as the buri	IF FEMALE 23b. Was d past 13 1 Yes Part II. Oth	2 No 9 🗸 Uni			5 Othe	r (Specify)					
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Division of Vital Records, tal or Attending Physician: The law require at safer death. In Director: After this certificate has been sifed in by the funeral director, page 2 should be difficultion. To De Committed at the death	examin		Hospital: 1 Inpa	tient 2	ER/Outpatient	3 DOA	Other ₄	Nursing Home 5	Residence 6	Other:	
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ivis lor A after Direction	1 Na 2 Ac 3 Su 4 Ho	icide 6 Coul	ld not be 28e. Place of	Injury - At ho	me, farm, street,	factory, office	building, etc	28f. Location or Town,		or Rural Route Number, City	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the build had a suppletely filled in by the funeral director, page 2 should be detached for use as the build had a suppletely filled in by the funeral director, page 2 should be detached for use as the build had a suppletely filled in by the funeral director, page 2 should be detached for use as the build had a suppletely filled in by the funeral director.	4 Ho 29a. Certifi	micide	rmined (Specify)					1			
To the Ho within 24 I To the Fu completely	(Check only one)	Centrying Pi	hysician: To the best of miner:On the basis of ex	my knowledg	e, death occurre	d at the time,	date and pla	ce, and due to the ca	use(s) and manner a	es stated.	
To t com	29b. Signa	ture and title of certifie	and manner state	d			nse number				
,		0.51					.M.E.		February 23	(Month, Day, Year)	
13 KM	30. Name a	and address of nerson	who completed cause o	f death (Item	23a)					, 	
			sistant Medical Eya			oro Stroot	Politimo	. MD 04000			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FEB Day ERNEST FRANK JAHN 2011 8:35 AM Medical JŖ 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) MAR 12,1936 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday) Days Hours 1 XM 2 □ F Director 059-30-1447 74 PA. Usual Residence of Decedent or 28a-f show be filed within 72 hours after death with the Maryland Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No D.C. NONE WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 3700 NORTH CAPITOL ST. N.W. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' 1 X Yes 2 I If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 19<u>54</u>– 1 Yes 2 X No Specify: "natural", 3 🗌 Widowed 4 🔲 Divorced Year or Dates WHITE permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COMPUTER PROGRAMMER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **ERNEST** F. JAHN SR. THELMA STROM Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERNEST O. JAHN/SON SW MEDINA AVE., PORT ST. LUCIE, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 2-28-2011 RIVERDALE, MD. Signature of Funeral Service Ansee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 AVE., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ORONAR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine e attending physician and and for use as the burial Due to (or as a consequence of, Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: မ 1 Pnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide within 24 hours after death

To the Funeral Director:
completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) las uno 0005 7/24 5+1 2/23/// 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 MOLECULAR DR., SUITE 208, ROCKVILLE, MD. 20850 TRUONG BAO, M.D

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 3:44 PMM February Marilvn Janoff Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 78 yrs 8. Date of Birth Funeral 1 □ M 2**X** F Hours 12/31/1932 Yrs NY Director 080-24-1734 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 X Yes 2 No MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States Funeral 13 Redgate Court 20905 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X If Yes, Give Year or Dates 2X☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3√√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Customs Brokerage Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sophie Selden ပ Sidney Aisen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13 Redgate Court Silver Spring MD 20905 Beth Janoff - daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Beth Moses Cemetery Farmingdale, NY 3/2/11 22. Name and Address of Facility
Edward Sagel Funeral
Rockville Pike 21. Signature of Funeral Service Licensee M01163 Shock, or heart failure. List only one cause on each line.

Pneumonia Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of):

Respiratory Failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and a for use as the burial-transit Dehydration To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Month Day Year Pregnant at time of death been signed by the a should be detached 1 ☐ Yes 2 ∆ 9 ☐ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4X Unknown 1 🗌 Yes Division of Vital Records, cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No After this certificate Yes 2 XNo 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 X No ပ 1 Yes 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending n 24 hours after death.

Reference of the following the full of th Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 28/11 2 1165312 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Sudars Han Siva MD 8600 Old Georgetown Road Bethesda MD 20814

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 08364 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OHNSUN Year (1600 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arunde1 Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 19<u>47</u> · Carolina 1 M 2 F Months Davs Hours Min. pril 2 Director 214-48-8679 63 S. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Lothian 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5093 Sands Rd. 20711 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2X Married Yes 2 💢 No If Yes, Give 1 ☐ Yes 2X No Specify: 3 - Widowed 4 - Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th 1yr Homemaker None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Jenkins Myrtle Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Johnson(Husband) 5093 Sands Rd. Lothian, Md. 20711 20a. Method of Disposition 20b. Placy of Opposition Hame of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 \(\overline{\text{W}}\) Burlal 2 \(\overline{\text{Cremation}}\) Cremation 3 \(\overline{\text{Removal from State}}\) Analogous Permoval from State 4 \(\overline{\text{Donation}}\) Donation 5 \(\overline{\text{Other}}\) Other (Specify) Cemetery 3 - 2 - 11Lothian, Md. Signature of Funeral Service Licensee Miname Research Security Sons Mortuary, 821 West St. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: ည 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29d, Date signed (Month, Day, Year) 242011 who completed cause of death (Item 23a) (Type, Print) ANNAPOUR MANYOI 31. Date filed (Month, Day, Year) FEB 2 8 2011 /32. Registrar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 9:15 PM RUSSELL JACKSON 201 LARRY Jarch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Jarrettsville Harford Crossgate Court 1701 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 187195I Months Days Hours Maryland 213-54-2880 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Jarrettsville MD. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with United States 21084 1701 Crossgate Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

14 Yes 2 1971 þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify. White 3 Divorced "natural", Completed 1972 Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Machinist Coal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Densel Jackson Majorie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 (Wife) Madonna Jackson 1701 Crossgate Court Jarrettsville, MD. 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Fallston, Maryland Highview Mem. Gardens 201 21. Signature of Funeral Service Vice 22. Name and Address of Facility E.G. Kurtz & Son Funeral Maryland Home Jarrettsville, 23a. Part 1. Enter the disease, or complications that rely sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or earline. Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) week Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown detached 9 Unknown Division of Vital Records, P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been sig page 2 should b 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify within 24 hours after death. To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗎 No Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicias 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number

State

Registrar

Date filed (Month, Day, Year,

6 2011

of death (Item 23a) (Type, Print)

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene amend #19a Per FH G914 4/04/2011 JH

Certificate of Death

Reg. No. 0 For State Registrar 08366 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year 1814 Charles William Jones 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Regional Medical Cumberlance Allegany Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Wash.D.C. Min. Months Hours 03/17/1932 Director Yrs 578-40-5488 78 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 ☐ Yes 2 🕅 No Allegany Little Orleans 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31727 Old Adams NE 21766 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 2 🗌 No Maryland 21215-0036 M Specify. 1 ☐ Yes 2 🔯 No 3 Widowed 4 Divorced Completed Year or Dates 1953-56 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Federal Government Electronic Specialist Be 17. Father's Name (First, Middle, Last) **Rubert** 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Robert Jones Dessa Hester Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31727 Old Adams NE Little Orleans, MD 21766 Phyllis +6. Jones/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gap Veterans 03/15/2011 Flintstone, MD . Signature of Funeral Service License 22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final nset and leath Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be ė Hospital 1 🔲 Yes 2 1No Other: 24 hours after death.

Funeral Director: After this reted filled in by the funeral directed in the funeral directed filled in by the funeral directed filled f 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) argalo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 E National Highway LaVale, MD 21502 M.D Shiz Khanna, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 857 AM Michael E. Kaimakis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Rosedale BalTimore Square Hospital FRANKLIN 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Greece 1 **X**M 2 □ F Min. May 31, T931 Director 79Yrs 217-40-8578 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland Director 10d Inside City Limits or 28a-f sh notified a MD Baltimore 1 X Yes 2 No 10e, Street and Number 9 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be with 1 Funeral 253 South Ellwood Avenue 21224 USA hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Mechanical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental He flect of Health and Mental He fitem 27 is marked ot rother traumatic ever ၉ Evangelos Kaimakis Kalliopi Sviga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela M. Kaimakis/Spouse 253 South Ellwood Avenue Baltimore, MD 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cem. Baltimore, MD 03/03/2011 21. Signature of 22. Name and Address of Facility Beall Funeral Home uneral ervice L 6512 NW Crain Highway Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final Physician/ multiorgan disease or condition resulting in death) 8 days Medical Due to (or as a consequent e of): Examiner Seps15 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) after death. Director: After this certificate has been signed by the attending physician and 4 in hv the funeral director, page 2 should be detached for use as the burla-transit Hospital or Attending Physician: The law requires that the death certificate be executed Oneumo Decitoneum
Due to (or as a conseduence of): that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examinet? Hospital: 2 🗌 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Natural 5 Pending Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 only one) 29b. Signature and title of certifier Gangalan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md 212 Square DR Balto Ganga 4000 FRANKLIN nth, Day, Year)
MAR 0 1 2011 State

Registrar

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Fu Dire permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important If item 27 is marked other than "natural" or items 33a or 38a.4 show Baltimore, Maryland 21215-0036 Physi Me Exan To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

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		For State Registrar		State of N	/larylar		Health and N <i>Death</i>		gien Reg. N	20		08368	?	
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xamin	er	Laurel	Region	1 . 1	1		l	aure Death			c. County Prin		George's	
neral ector		5. Social Security Nu 681-10-4	If Under 24 Hrs. Hours Min.	8. Date of Birt Ju ^{Month} ,1 ^{Day}	th y, 19	50	9. Birt	hplace (State or Foreigr dia dia	7					
d at	tor	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits	
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important, it ten 21 is market other than hadran, on terms sea or sea-t show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		19a. Informant's Nai Rana Sir								ber, City or Town, State, Zip Code)				
or other		20a. Method of Disp 1 🗌 Burial 2		X Removal from Sta		Place of Dispo	sition (Name of matory or other pla		Date				Town, State	_
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cian/ dical niner		disease or condition resulting in death)		a. Bronch Due to (or a		Sthma Jence of):	WITH	Preumoni	d			+	1 day	
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funeral		27. Manner of Death	5 Pending	28a. Date of in (Month, D	ury	28b. Time of injury	28c. Injur worl		28d. Describe h				<u> </u>	_
in by the	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Place of Ir	jury - At ho tc. <i>(Specify,</i>				eation (Street and Number or Rural Route Number, y or Town, State)					
ited filled	Medical	29a. Certifier 1	Certifying Physical Exa	nysician: To the best of miner: On the basis of	f my knowle	edge, death o	occured at the time	e, date and place, an	id due to the cau	use(s) a	nd manne	er as state	red. ause(s) and manner state	ed.
сотріє	Ž	only one) 3 l 29b. Signature and ti		urse Practioner: To th	e best of my	knowledge, o	death occurred at the 29c. Licens				. ,		Day, Year)	-
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State gistra	e r	31. Date filed (Month,	AR 012	2011 32. Regist	rar's Signat	B. A	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08369 State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 03:00 PM Physician MARCH 03 2011 Keesecker Virginia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Western Maryland Hospital Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Days Hours Min. Funeral Months 1 ☐ M 2 🗓 F 63 Washington DC 1947 April 6, Director 579-58-18<u>42</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Directo Maryland | Washington Sharpsburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21782 4861 Churchey Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 X No Yes, Give 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: 21215-0036 If Yes, Give Year or Dates: \$ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 8 h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland es 1 and 2 should be fil of Health and Mental H i Item 27 Is marked oth Be Preves <u> Margaret</u> Keesecker 2 <u>William</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21782 4845 Churchey Road Sharpsburg, Maryland Sandra J. Henson/Foster Sister other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03-07-2011 | Sharpsburg, Maryland Samples Manor Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 21. Signature of Fu 7606 Old National Pike Boonsboro, MD 23a. Part1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use or leach line. Immediate Cause (Final disease or condition WEEKS **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): YEARS RENAL DISEASE Examiner STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and sthe burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical 28 attending IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death nse 23b Was decedent pregnant 3 ☐ Ectopic pregnancy Vear Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ARTERY DISEASE CORONARY page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES MELLITUS autopsy performed? Yes 2 2 No has 2 No 1∐ Yes ACCUDENT. CEREBROVASCULAR Vital sspital or Attending Physician: I hours after death.

neral Director: After this certificat iy filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 ☐ D**O**A 1 ☐ Yes 2 No Certification: To ō 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 28a. Date of Injury 27. Manner of Death (Month, Day Year) Injury 1 Natural 2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0062895 M MARCH

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State

Registrar

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31. Date filed (Month, Day, Year)

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARDS

32. Registrar's Signature

DAGGY

MAR Q 4 2011

1500 Pennsylvania Avenue

Hagerstown, MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 A A CH Dorothy Jean KARPER Medical 4)1 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Dec. 28, 1919 Months Days Hours Min. 91 **Director** 219-36-2800 Pennsylvania Usual Residence of Decedent 10a State notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Washington Hagerstown 1X Yes 2 No 5 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 1 10g. Citizen of What Country? with 1 Funeral 914 Guilford Avenue 21740 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry filed within 72 ial Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 statistician State of Maryland e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ C. Sharpe Karper Nora Deardorff permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Taylor - friend 11041 Roessner Avenue, Hagerstown, Md. 21740 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 XBurial 2 Cremation 3 Removal from State Norland Cemetery 3/5/11 Chambersburg, Penna. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Preumon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or linjury Examine Due to (or as a conse uence of) the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? į 5 Other (specify) Month Dav Year 2 🗌 No detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed After this certificate I 1 ☐ Yes 2 【 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, to or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionars To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28361 3-2-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-7 368 Street Hagerstown 1902/740 2 C neilo 2AR HAR1 AN 31. Date filed (Month, Day, Year) 32. E State

08371 State of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health and Mental Hygien of Maryland / Department of Health And Mental Hygien of Maryland / Department of Health Maryland / Department 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Arthur Kennard 1136 Fay M 🖊 02 Medical 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of Meryland Madie B-1+1mor . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6 23 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1941 1 Q M 2 □ F Days Hours Country) MD 212-40-7786 **Director** 69 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD KENT Pomona 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6759 Church Lane 21620 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 SpecifyBlack 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates. I 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Factory Worker other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 10 th College (1-4 or 5+) Chestertown Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Lee Thomas Kennard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 6759 Church Ln Pomona MD 21620 Betty Ann Kennard-wife 20a. Method of Disposition | X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ot 20c. Location - City or Town, State Date cemetery, crematory or other place)
Emmanuel U.M. 3/5/2011 Pomona, MD Donation 5 - Other (Specify) 22. Name and Address of Facility Renneth Walley Funeral ervice 821W. St. Annapolis, MD 21401 21. Dignature of Funeral S vic. Licensee Service 821W. (00026) Part 1. Exher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Interval Between mmediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Urose ps 15 Medical Due to (or as a consequence of) **Examiner** ~ who i land Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury 1 month suprather cpa attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) MAPPROVED BY MEDICAL EXAMINER Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day sate has been signed by the a page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown proster Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No ☐ Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100796 2/25/2011 und MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 5. Green St., Boltimore, MD 21201 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FRIDA KARAGOZIAN FEBRUARY 2011 9:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 105 CLEARSPRING PLACE QUEEN ANNE'S MILLINGTON . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Hours Min 06/03/1935 JORDAN Director 322-36-7311 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No QUEEN ANNE'S MD MILLINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 CLEARSPRING PLACE UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 leth and Mental Hygiene.
27 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING ASSEMBLER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ELIZABETH KARAGOZIAN JOHN AKMAKJIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 105 CLEARSPRING PLACE MILLINGTON, MD 21651 JIMMIE KNIGHT - HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 02/24/2011 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22, Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEÉR ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complete ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death cause on each line.

Meta tatic shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day 1 Yes 2 P.0. s been signed by t should be detach II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Metastuses to Bone, Musile and Lymph Nodes Completed by Records, 1 🗆 Yes No 3 🗆 Probably 4 🗀 Unknown Hypotensian, Anxiety Cluser Intokrunce Depression / Grief Reaction 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has perform 2 No 1 Tes 25. Was case referred to medica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 🛂 No Other: ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Residence 6 Other (Specify) 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 Speer Road Chestertown, MD 21620 Rin State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Hebruary Day 27, 2011 4:35 A M Physician/ Ellsworth Keyser Burton Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (if not institution, give street and number) Examiner Calvert Prince Frederick 1280 Lottie Fowler Road Birthplace (State or Foreign Country)
 T7 A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex 1 X M 2 - F Social Security Number Funeral Days VA 90 Director 178-18-4221 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County Director 1 🗌 Yes 2 🍱 No Prince Frederick Calvert 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20678 1280 Lottie Fowler Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1

Yes 2 □ No 2 1 Never Married 2 X Married 1 Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Government Engineer 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ည Bessie Taft Robert Burton Keyser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 353 Overlook Drive, Lusby, MD 20657 Linda Callan / Daughter Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Lively, VA 03/02/2011 Bethel UMC Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Juneral Service Licensee 8125 Southern Maryland Blvd., Owings, MD 20736 Gary J. 23a, Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Year in the past 12 months? Yes 2 No 1 ☐ Yes 2 ☐ Unknown on the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home Seridence 6 Other (Specify) 27 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes Certificate: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 2 To the F 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hosp: tal Rd, Ste 310, PRince Frederick MD20678 Lowenthall MD Tonathan 31. Date filed (Month, Day, Year) 32. Registra Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Harrington Kuster 11:45P M Medical February 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days Hours Director 721-07-8106 Yrs 85 Mary Land Usual Residence of Decedent shov 10a. State 10b. County filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Montgomery 1 Yes 2 X No Rockville 10e. Street and Number items 23a or ner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 304 Woodburn Road 20851 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) traumatic event, the Medical Examiner Race - American Indian, Black, White, etc. ō by 1 Never Married 2 X Married Yes, Give WW II 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural" White 3 Divorced 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 8 Relief Map Maker Army Map Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental inportant; If item 27 is marked o any injury or other traumatic eve once. and Mental F ၉ Elmer Joseph Kuster Annie Rebecca Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Patricia Groseclose Kuster 304 Woodburn Road, Rockville, MD 20851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) March 2, 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial 2011 Rockville, MD 22. Name and Address of Facility
DeVol Funeral Home, 10 East Beer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Lisensee RACI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pneumonia Medical Examiner Due to (or as a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending place as detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown plnous peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2: autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: 2 X No ည 1 X Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: After 28d. Describe how injury occurred 1 X Natural Pending s after death.

I Director: Aff
id in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check To the I within 2 29b. Signature a title of certific 29d. Date signed (Month, Day, Year) 8+1 1065312 2/28/11 ddress of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814 Sudarshan Siuq, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 01 2011 MAR Registrar

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month February Marilyn 2011 1:45 a M Jean Komaromy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3702 Dupont Avenue Kensington Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Y 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs Funeral 9. Birthplace (State or Foreign 1 M 2 X Country) Wisconsin **Director** 1930 397-26-5616 80 28a-f show 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Kensington 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 3702 Dupont Avenue 20895 USA death v 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian Black, White, etc. 0 1 Never Married 2 Married þ 1 X Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced Completed Year or Dates. 1951 - 53the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Law Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Edgar Krueger Almeda Ida Senn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Amy Komaromy Chalker/Daughter 2907 Lindell Street, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial ZXX Cremation 3 Removal from State cemetery, crematory or other place) 2/28/11 4 Donation 5 Other (Specify) Alexandria, VA Metropolitan Crematory 21. Signature of Tuneral Service V censee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Tychord & Jates 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph sician/ Cancer with metastases to the brain disease or condition DOU-Medical resulting in death) Due to (or sus consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunding the page 2 should be detached for use as the bunding the page 2 should be detached for use as the bunding the page 2 should be detached for use as the bunding the page 2 should be detached for use as the bunding the page 2 should be detached for use as the bunding the page 2 should be detached for use as the bunding the page 2 should be detached for use as the bunding the page 3 should be detached for the page 3 should be a should be a should be detached for the page 3 should be a should be Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ເNo 5 Other (specify) Month Pregnant at time of death Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 SarYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No |@ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2-28-2011 D 37142 address of person who completed cause of death (Item 23a) (Type, Print) MD Suite. 100 Piccord Drive 1355 Rockville MD G. Coleman 31. Date filed (Month, Day, Year) State Registrar

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State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate	of Death	Reg. No		00010
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Ray Samuel Linebaugh		2. Date of Death Month Day February 28, 2		3. Time of Death 1020 hrs
		4a. Facility Name (if not institution, give street and number) 1-70 at Exit 12	4b. City, Town, or Location of Death Clear Spring	4	c. County of Death Washington	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth (MM	I/DD/YYYY) 9. Birth	place (State or
Director		212-38-8712 1XM 2F 69	Months Days Hours Min	02/19/194	Foreign Cour	Maryland
w any		10a. State 10b. County 10c. City, Town or Loc	cation			0d. Inside City Limits
Maryland 28a-f show 1 at once,	tor	Maryland Washington Hager	stown 10f. Zip Code	140- 09	tizen of What Count	1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Opparment of Health and Mental Hygene other than fire important: Witner 123 no 28a-f sho important: Witner 123 no 28a-f sho njury or other traumatic event, the Medical Examiner must be notified at once.	Director	11935 Heather Dr.	21740		S.A.	y?
ath with items 2.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - America White, etc.	an Indian, Black,
after de sal", or incr mu	by Fu		Yes 2 No specify:		Specify: Whit	·e
2 hours "natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	lent's Usual Occupation (Give kind of v most of working life. DO NOT use reti	vork done 16b. red)	Kind of Business/Inc	
5-0036 led within 72 Hygiene. other than	Completed	12	U.S. Air Force	Fe	deral Gov	vernment
215-(e filed v tal Hygi ked oth	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden	Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 permit. Pages I and 2 should be filed within 7 logariment of Health and Northal Hygiene. Important: If item 27 is marked other than hijury or other traumatic event, the Medica	70	Robert L. Linebaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Mary F ling Address (Street and Number or F	Clizabeth Rural Route Number, C	SemLar City or Town, State, 2	Zip Code)
e, MI I and 2: Health a item 27		20a. Method of Disposition 20b. Place of Disp	ont Valla Ave. Hag	erstown M	Saryland 2 Location - City or To	21740 own, State
Baltimore, vermit. Pages I an Department of Hea Important: If itel injury or other tr.		1 X Burial 2 Cremation 3 Removal from State crematory or 4 Donation 5 Other Specify: Rose Hill	' '	3/2011 Hag	raretorm	Maruland
Balti permit. Departu Import		21 Signature of Frineral Service Licensee 22	. Name end Address of Facility Res	t Haven Fu	ineral Cha	ape1
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	601 Pennsylvania r the mode of dying, such as cardiac o	Ave. Hager r respiratory arrest, sh	stown Mai	Approximate Interval
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):		· .		Between Onset and Death
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	Examiner	if any, leading to immediate cause. Enter Underlying Cause				
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760, ficate be executed g physician and the burial - transi	Medical	UNPENDED AMENDED IF FEMALE: 23c, if yes, outcome of pregnancy			-21	
		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2	Fetal death 3 Ectopic pregna		d. Date of delivery Month Da	y Year
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
i, P.O. ires that the signed by be detach	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the	
ords, v require s been si should b	leted			24a. Was an	24b. Were auto	psy findings available
	Completed			autopsy performed? 1 ✔ Yes 2 N	death?	npletion of cause of
fital Resident: The list certificate lirector, page	a	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26.Place of Death (Check of nt 3 DOA Other Nursing	only one) g Home 5 Reside	ann e le Cotton e	
	n: To	27. Manner of Death 28a. Date of Injury 28b. Time o	f Injury 28c. Injury at Work?	28d. Describe how injudent auto collision	ury occurred	ocerie
	icatic	2 Accident Investigation 28e Place of Injury - At home form str	1 Yes 2 ♥ No	28f. Location (Street a		Pouto Number City
Division spital or Attentions after death rectors after death rectors after death rectors after an object of the spital process.	Certification:	4 Homicide determined (Specify) Interstate/Express		or Town, State) I-70 Exit 12, Clear S		Rodie Number, City
Divisic To the Hospital or Atte within 24 hours after dea To the Funeral Director completely filled in by th	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place, and pation, in my opinion, death occurred e	due to the cause(s) an	nd manner as stated	cause(s)
T wit	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month	
2+1		30. Name and address of paragraphs	O.C.M.E.	Mar	rch 1, 2011	
<i>↔</i> .		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Ba	Itimore Street, Baltimore, MC	21223		
St Regist		31. Date filed (Month, Day, Yar) 32. Begistrar's Signature	Wild			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:40pm _M Physician/ Robert Alvin Leiss Febont 22, 2041 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington DC **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 577-50-9504 1 X M 2 - F Days Hours Min Jan 12Director Usual Residence of Decedent 28a-f show 10a. State Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Chevy Chase 1 X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 3103 Cummings Lane 20815 United States within 72 hours after death 12. Was Decedent Ever in U.S
Armed Forces? 2-1
1 ▼ Yes 2 □ No
If Yes, Give 12= 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2-1956 Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 12 = 19591 Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer's Rep Furniture Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grayson Wise Leiss Cornelia Ann Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bren Leiss/Wife 3103 Cummings Lane, Bethesda, MD 20815 Baltimore, 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem 2-25-2011 Silver Spring, MD Signature of Fureral Service Lisensee 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faildre. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Septic Shock disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-granist attending physician and for use as the burial-ransit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Bacteremia 24a. Was an autopsy performe 2 X No 1 Yes 2 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural iniury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 D 66249 Feb 22,2011 miss.

Registrar

State

Registrar's Signatur

1500 Forest Glen Rd, Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Duran

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 28b, d per me g917 7-18-11 vt

State of Maryland / Department of Health and Mental Hygiens () | | State
Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death rebruary 4:30 PM Physician/ Yuk Kim L00 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Prince George's Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, Year) July 02, 1949 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Days Months Hours China Director 579-72-2118 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🛛 No New Carrollton Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5916 20784 85th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Máryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Asian 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) Film Laboratoru Film Processor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Pak Hei Cheuna Hap Leurna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Lee - Daughter 118 Monroe Street. #403. Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Washington Natl. Cem.: 03/02/2011 | Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physiciaπ/ OGON disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) After this certificate has been signed by the attending physician and fineral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death
☐ Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day 2 1110 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has the in by the funeral director, page 2 st autopsy performed? Yes 2 No 1 Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗆 No ER/Outpatient 3 DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred subject fell 28b. Time of Certificate: 28c. Injury at 1 Natural
2 Accident 5 Pending unknown Investigation FEB. 23, 2011 within 24 hours after de To the Funeral Directo 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5916 & STRAVE, NEW CARROLLTON, M.D. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined HomE Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat and title of certifier ene 00068976 LAWHAW, HO JOTOLO 8118 GOOD LUCK ROAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doc 31. Date filed (Month, Day, Year) NAR 02 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cora H. Mason February 2011 4:30 Рм Medical 4b. City, Town, or Location of Death Annapolis 4a, Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 601 Creek View Avenue Anne Arundel Jate of bin. Month, Day Yea 7. Age (In yrs. last birthday) 90 vre 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 245XF Months Davs Hours 229-34-6915 Michigan Director Jan. 1921 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Annapolis XXYes 2 No 601 Creek View Avenue 10f. Zip Code 10g. Citizen of What Country? $U_{\bullet}S_{\bullet}A_{\bullet}$ 21403 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or item Examiner n 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: White Specify: "natural" Completed **¾X**Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "any injury or other traumatic." other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Elementary School Librarian Be 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Maud Keller 17. Father's Name (First, Middle, Last) Dr. Andrew Roy Hackett 19a. Informant's Name/Relationship (Type, Print)
Diana Ranocchia/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 608 6th Street Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🕱 Cremation 3 🗍 Removal from State Ft. Lincoln Crematory 3/1/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chiline. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Day 5 Other (specify) Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform has Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 10 Hospital 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) After this funeral . Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \(\text{Yes} \quad 2 \(\text{No} \) Natural iniury 5 Pending 24 hours after death, Funeral Director: A Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the i 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 20 who completed cause of death (Item 23a) (Type, Print) and address of YKWY STE 210 2003 Medium V 31. Date filed (Month, Day, Year)

MAR 0 1 2011 State Registrar

State of Maryland / Department of Health and Mental Hygien 🖗 🚺 📗 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February 23, 2011 8:00 Ам Beverly Claxton Moore Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 101 Colton Court Washington Smithsburg Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Oct. II. , Year) 934 1 ☐ M 2 🕮 F Min 74 Yrs. Washington, D.C. Director 578-50-3244 Usual Residence of Decedent 28a-f show 10a. State West ms 23a or 28a-f shormust be notified at 10b. County 10c City Town or Location with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2XX No Virginia Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 COlorado Court 25419 United States items (filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ö 1 Never Married 2 Married ģ Maryland 21215-0036 ☐ Yes 2 🖾 No Specify: White "natural", Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Computer Programmer Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Department of Health and Menta Important: If item 27 is marked any injury or other traumation once. မှ Roy Claxton Agnes Holderith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stefanie Browning / Daughter 101 Colton Ct., Smithsburg, MD 21784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens Date 28 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🖊 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2011 Frederick, Maryland Signa Funeral Pervice Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the dis shock, or heart fail Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Extensive disease or condition Medical resulting in death) Due to (or as a consequence) Examiner Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Day to for as a consequence of burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) Yes 2 No the 9 Unknown 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence daughter's 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: injury 1 X Natural 5 Pending Accident 2 No Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier D68995 MAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haperstown, NAD 21740 10 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 24, 2011 Gus McIntyre 11:07 a^M George Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. T. (Month, Gay, 9. Birthplace (State or Foreign Country) D A Social Security Number 7. Age (In yrs. last birthday) **Funeral** Nov. 14, Year 1918 1 🔀 M 2 🗆 F Months 187-18-8849 92 PA Yrs **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director Silver Spring MD Montgomery 1 🗌 Yes 2 🎞 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20906 3903 Weller Road permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Black, White, etc. Armed Forces' þ 1 Never Married 2 Married ¥Yes 2 □ No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give WWII Completed 3

▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Map Reproducer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara L. Eulitz 2 George Sam McIntyre 19a Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Mimosa Avenue, Pasadena, Albert McIntyre/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State 2/28/2011 1 Burial 2 Cremation 3 Removal from State Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signavire Funeral Service Lice rancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or comp ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Gunshot Wound to Head, Self-Inflicted Medical Due to (or as a consequence of): m Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and the for use as the burial rehis that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Yes 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Ilnknown funeral director, page 2 should be detach Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 △ Yes 2 □ No Vita Be 26. Place of Death (Check only one) ျှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2. No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1/00 M Accident Investigation 745 17 2011 3 X Suicide 6 Could not be 28f. Location (Street and Number of Rural Route Numbers)
City or Town, State) 3 9 3 Weller 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Home Spring MD 20906 Medical owledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of 29a. Certifie Medical Examiner: On the basis of xamir Certifying Nurse Practioner: To the best onta one) f my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) ρ 29b. Sig Feb. 28, 2011 D42181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Enrique D. Racines, MD 6420 Rockledge Drive, Bethesda, MD 20817

State

Registrar

31. Date filed (Month, Day, Year)

MAR 01 90

60:11

2. Registrar's Signature

08382 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death February 26, 2011 Francis L. Mann Physician/ 8:00p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Gaithersburg Wilson Health Care Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min Year) 916 1**X** M 2 □ F FEB 29, Washington **Director** 578-32-1925 94 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Gaithersburg Maryland Montgomery 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral United States of America 403 Russell Ave #104 20877 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Caucasian Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) oermit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) US Dept. of Army Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Deuber John Henry Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Russell Ave #104, Gaithersburg MD 20877 Jean Mann - Spouse injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 03/07/2011 Brentwood, Maryland 22. Name and Address of Facility imple Tribute Funeral & Cremation 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 14 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician/ YPUM disease or condition Medical resulting in death) Due to (or as a donsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death 1 Yes 2 g Unknown 2 No been signed by the should be detached g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital æ examiner? Hospital: 1 🗌 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nich 31. Date filed (Month, Day, Year, 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, Day 2011 Year Physician/ Feb. 6:45P M Patricia Mary Messick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8321 Newark Road Newark Worcester Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. 3-21, Day, Year 33 77 MD Director 214-32-0804 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No MD Worcester Newark 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 21841 USA 8321 Newark Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Completed white 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ital Hygiene. ed other than " event, the Mer Elementary/Seconday (0-12) 12College (1-4 or 5+) Homemaker Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Tawes Irene Causey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Ann Jarvis- Daughter 12933 Murray Rd. Whaleyville, MD 21872 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State First State Crem. Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 3/2/2011 of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home William Street Berlin. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Metastatic Colon Cancer 16 years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence or). il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 1 Yes 2 No 1 🗌 Yes 2 💂 completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 PResidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number C. Ersest Calle Irus. 00063253 2-28-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. ERHEST G. 65 Ja M.D. Market St. Saow Hill, MD 21863 728 W.

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08384 State of Maryland / Department of Health and Mental Hygiene ? State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **9:45A. P** Ercole Physician/ Joseph Mossi February 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Silver Spring c. County of Death Montgomery Holy Cross Hospital 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Days Jan. 14, 1936 **Director** 577-48-4240 Washington, DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Beltsville 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3402 Dunnington Road 20705 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced (unk) Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Arturo Mossi Josephine Mary Gagliardi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Belle Mossi -wife 3402 Dunnington Road Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Gate of Heaven Cem. 3/4/2011 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonald Wors Borg Wardt Funeral Home, lonald 4400 Powder Mill Road Beltsville, Maryland 20705 ca 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final 3 months Ph_sician/ Pancreatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-trunsh To the Hospital or Attending Physician: The law requires that the death certificate be executed Jause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown the 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □XNo 24a. Was an autopsy performed? Yes 2 X No certificate ! 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{\tint{\text{\tint{\text{\tinit}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texiext{\texi}\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texitile}}\text{\text{\text{\text{\text{\text{\texi}\text{\texitile}}\tint{\tiinttitex{\texitile}}}}\tiext{\text{\text{\text{\texitile}}}\t 1 Npatient 2 ER/Outpatient 3 DOA မ 1 Tes 2**X** No within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No 5 Pending Investigation Accident 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 University Blvd., #400 Wheaton, Maryland 20902 M.D. Cheryl Aylesworth, 31. Date filed (Month, Day, Year) NAR 0 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ February Thomas Mader Herman 3:38 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

Jan 3 1940 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours Jan. Director 213-38-1861 71 Minnesota Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State with the Maryland Director 1 🗌 Yes 2 🕱 No Md. Montgomery Montgomery Village 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 9387 Chadburn Place 20886 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1959-1 New 2 No 1965 Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: 1965 Specify: White 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. and Mental Hygiene. U. S. Postal Service Postal Worker Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Herman Joseph Mader I. Johnson Agnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Teresa Ann Mader / Daughter 9387 Chadburn Place, Montgomery Village, Md. 20886 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crem. 2/26/2011 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signatury of Foreral Service Lightsee Name and Address of Facility Muriel H. Barber Funeral Home m-00470 P. O. Box 5038, Laytonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate hock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pulmonary Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence f): Examiner ongestive Sequentially list conditions, cause. (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 2 Accider
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) lane! Kane D068178 FEBRUARY, 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Ctr. Dr. Rockville, mD 20850 10+1 9901 Rane Santosh MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State مسالصفي عليه Registrar

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homas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 2:10 a M Eileen Hales Majors Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Center Dorchester Cambridge Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Year)19<u>15</u> Months Hours Min. April II, 1 🗆 M 2 🔯 Maryland 216-40-3630 95 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Dorchester Cambridge 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with the Funeral 304 Gay Street 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12 Was Decedent Ever in LLS 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 should be filed within 72 hours after 1 ☐ Yes 2 👿 No Specify: white "natural", 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. larked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the teacher county schools 11Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked o Granville Harrison Hales Nettie Elizabeth Collins permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Shepherd Avenue, Cambridge, MD Marylea M. Willey daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cambridge Cemetery 2/24/11 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatu φ Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 125 reek Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of If any leading to immedicause. Enter Underlying sician and burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death g Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 X Rio 1 Inpatient 2 ER/Outpatient 3 DOA 욘 this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural work 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 Tes 2 No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier To completed cause of death (Item 23a) (Type, Print) 30. Name and address of person v Branble 100 31. Date filed (Month, Day, Registrar's Signature

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certif	icate of	Death		7.0	Re	g. No.		
Physic		1. Decedent's Name (First, Middle, Last) 2. Date of Dea								Month	Day Year	,	3. Time of Death 2340 hrs
ledical Exar	nine	Conacine	ın A. Me				b. City, Town, or	- Location of		ebruary 2		f Dooth	2540 1115
		4a. Facility Name (if no 849 Harvest M		street and number)		1	Odenton	Location of	Death	4c. County of Death Anne Arundel			
Funera		5. Social Security Num		(7 Age	(In yrs, last	birthday)	If Under 1 Yea	ar If Under	r 24Hrs. 8	Date of Birth	n(MM/DD/YYYY)	9. Birth	place (State or
Directo					47		Months Day		Min	10/14/	•	Foreign	
		220-94-318 Usual Residence of De	7 A	M 2 F		Yrs.				10/14/	1903	Aim	(7MD
Any	ı		b. County		10c. City, To	wn or Location	on					П	10d. Inside City Limits
E.	ᆁ .	MD A	Anne Aru	ndel	0de:	nton							1 Yes 2 No
faryland	בן בן	10e. Street and Number 10f. Zip Code								10	g. Citizen of Wh	at Count	try?
the M	al Director	849 Harvest Moon Drive 21113											
with		11. Marital Status		12. Was Decedent	Ever in U.S.		Decedent of His						an Indian, Black,
death	Filhera	1 Never Married	2 X Married	Armed Forces?	Ţ No	IT Ye	es, specify Cubar	n, Mexican,	Puerto Ric	an, etc.)	White	Whi	+0
after	2 2	3 Widowed		If Yes, Give Year or Dates:			Yes 2 X No				Specify:		
hours	91 —	15. Decedent's Educ					's Usual Occupa st of working life				16b. Kind of Bus	siness/in	dustry
36 hin 72 e. than	Completed	Elementary/Second	ary (0-12)	College (1-4 or 5)+)	Stav	at home	dad			Own H	ome	
d with		17. Father's Name (Fir	st, Middle, Last)						s Name (Fir	rst, Middle, M	aiden Surname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	# P		leeder					Judi	th We	rle			
21.		19a. Informant's Name	/Relationship (Ty	rpe, Print)				et and Numl	ber or Rura	Route Num	ber, City or Towr		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.		Jessica H	lamman Me	eeder Wife							on,MD 2		
Te, l and l'Heal		20a. Method of Dispos		Removal from Sta		ce of Disposi natory or oth	tion (Name of ce er place)	metery,	Da	ate	20c. Location -	City or 1	own, State
Pages lent of	or other traumatic event, the Medical Exa	4 Donation 5	_			Marga			03/02	/2011	Annapo	lis,	MD
Baltimore, MD 21215-003 permit, Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If trem 27 is marked other the		21. Signature of Funds		ee //		22. N	ame and Addres	a of Facility					olis Road , MD 21054
™ 80 4 1.		Daw 1	y a	1//									
Physicia Medica		23a. Part I. Enter the of failure. List only			the death. Do	not enter th	e mode of dying,	, such as ca	ardiac or res	spiratory arre	st, snock, or nea	irt	Approximate Interval Between Onset and Death
Examine		Immediate Cause (Fin or condition resulting i	_	Cardiac Arrhythi									Degni
			ь (Cardiomegaly w		ricular Dila	atation						
	miner	Sequentially list condi- if any, leading to imme	ediate C	us to (or as a conse	quence of):								
		cause. Enter Underly (Disease or injury that	initiated ^{C.} -	Oue to (or as a conse	equence of):								
nted d	- transit	events resulting in dea	atn) Last - d.		4								
60, ate be execut	ounal - us	UNPENDED		AMENDED									
60, ate be	Medical	IF FEMALE:		23c. If yes, outcom	ne of pregnan	icy					23d. Date of	delivery	
687 ertific		23b. Was decedent pre past 12 months?	egnant in the	1 Live birth	time of death		al death 3	Ectopic	pregnancy		Month	D	ay Year
Box 687 ne death certific	Dhveirian	1 Yes 2 No	9 Unknown	9 Unknown	une or death	5 Oth	er (Specify)						
the d	iched a	Part II. Other significa	ant conditions		but not resu	Iting in the u	nderlying cause	given in Par	rt I.	23e. Did tol	pacco use contri	oute to t	he cause of death?
, P.O.	P P	Polycystic kid	lney disease							1 Yes	2 No 3	Proba	ably 4 🗹 Unknown
ds, equir	Completed									24a. Was a			opsy findings available ompletion of cause of
COT law I	e 2 sn						-			autops perform 1 Yes 2	med? d	eath?	
tal Reco	ر. pag	25. Was case referred	to modical				26 Place	e of Death (Check only		No 1	✓ Yes	2 No
ital sician	airector, page	examiner?	[H	ospital: 1 Inpatie	nt 2 EF	VOutpatient					Residence 6	Other:	Scene
of Viring Physical After this		1 Yes 2 27. Manner of Death	No	28a. Date of Inju	ry 28	Bb. Time of In		ury at Work?			ow injury occurre		
endin ath.		1 Natural 5		(Month, Day, Y	ear)		1	Yes 2	No				
Division of Vital Records, P.O. talor Attending Physician: The law requires that the safer death.	i oy i	2 Accident 3 Suicide 6	Investigation Could not be	28e Place of In	ury - At home	e, farm, stree	t, factory, office I	building, etc	c. 28f			r or Rur	al Route Number, City
Dital o	Cartification	4 Homicide	determined							or Town, St	ate)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	~	Torroom orany		n: To the best of my									
To the To the	Vompletely	2		On the basis of exar and manner stated.	nination and/	or investigati			arred at the	e ilme, date a			
	2	29b. Signature and title	e of certifier	11/	Se-		29c. Licens				29d. Date signe February 2:		
		Mille	u Bra	self, 11	02		O.C.	.IVI.C.			i culualy 2	J, ZU1	
Juli .		30. Name and address Melissa Brass		ompleted cause of d sistant Medical			. Baltimore S	Street Ra	altimore	MD 2122	3		
'HTT	Stat	31 Date filed (Month	Day Year)	32 Bagistra						= 155			
Reg		FE	B 2 8 20	11 Dener		. pa	Ned.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A M KATHERINE MOORE **FEBRUARY** 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner OUEEN ANNE'S** 212 PINEY POINT LANDING GRASONVILLE Social Security Number Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F FEB. 21, Months Hours Min. NEW YORK Director 106-26-0268 76 Usual Residence of Decedent 10a. State 10b. County ms 23a or 28a-f shormust be notified at 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No MARYLAND QUEEN ANNE'S GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 212 PINEY POINT LANDING 21638 UNITED STATES items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ò Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE "natural". 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. the LEGAL SECRETARY T.AW ed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ FRANK TIERNAN other traumatic CATHERINE NICHOLSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS MOORE/SON PROSPECT BAY DR., GRASONVILLE, MARYLAND 21638 20a. Method of Disposition
1 → Burial 2 → Cremation 3 → Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 0 MARCH 1 2011 Important: It any injury or 4 Donation 5 Other (Specify) PETER'S CEMETERY QUEENSTOWN, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
106 SHAMROCK ROAD, CHESTER, MARYLAND . Signature of Funeral Service Licensee HOME P.A. 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death detached 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of s after death. 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation pleted filled in by the Accident Suicide Could not be 3 ☐ Suiciae
4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral D the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person ynthia Hudtaker 31. Date filed (Month, Day, Year)

32. Registrar's Signature

29c, License number

29d. Date signed (Month. Day, Year) 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 08389 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u>David Delmar Myers</u> Medical March 5:06 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4511 Valley View Road Middletown Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland Funeral Months Days Hours (Month, Day, Year) 06/28/1964 Director 212-72-5171 46 Yrs Usual Residence of Decedent 23a or 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No MD Frederick Middletown 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4511 Valley View Road 21769 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 Xio Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗖 No Specify. white 3 Widowed 4X Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than 12 <u>sheet metal mechanic</u> HVAC / sheet metal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill them of Health and Mental rtant: If item 27 is marked oughry or other traumatic ew ဨ Larry D. Myers Shirlev L. Crum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Shirley Myers / mother 4511 Valley View Road, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 3/9/2011 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home Dancelle Brief MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pulmony Embelis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by Chroni pan' - Newopathy 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed' 1 ☐ Yes 2 Z No Yes 2 No eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 3/7/11 D43780 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3005church St Biddle town m) 21769 Keym E. Hohl ms 31. Date filed (Month, Day, Year, 32. Registrar State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 2115 PM CA ZOIL a Class Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Macyland Baltimore 0 1timoce If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**X M 2 □ F Washington, D.C Director 578-56-6441 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland Anne Arundel Crofton 1 XXYes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21114 2306 Putnam Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes ※XXXo Completed by 1 Never Married 2 XX Married Yes Maryland 21215-0036 White 1 ☐ Yes XXX No Specify: If Yes, Give Specify: and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Sales C.B. Flooring permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important; If item 27 is marked other any injury or other traumatic event, <u>th</u> once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Najarian Piloon Manoogian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2306 Putnam Lane, Crofton, Md. 21114 Sue Najarian /wife Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Huntt Crematory 1 ☐ Burial XX Cremation 3 ☐ Removal from State 2/28/11 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6000 Annapolis Road, B owie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical as a consequence of) Examiner neumonia with Pseudo Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No should be detached for 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown the 9 Unknown ģ II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HTN, CAD, pulmonary Gibrosis, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings avallable prior to completion of cause of death? 24a. Was an autopsy disease, MCTO, has page 2 performed 1 ☐ Yes 2 ☐ No certificate Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide Investigation 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08391 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Brenda Lee 10: 22 AM Nutter 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Salis bury Rehabilitationa Nursing Ctr 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Wicomico disburu 1 Year If Under 24 Hr 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 946 1 🗆 M 2 🏻 F Months Days Hours Min. Sept. 4 Maryland 64 Director 216-44-8327 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland at 10d. Inside City Limits Director or 28a-f sh notified 1 Yes 2 No Maryland Wicomico Nanticoke 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ritems 23a or ner must be n ò Funeral 2709 Bank Road 21840 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 3 Married 1 Yes 2 X No Specify: Specify: If Yes, Give 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Drafting Clerk Bell-Atlantic/Verizon Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Satchell Bivans Naomi Elwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2709 Bank Road, Nanticoke, Maryland Edward Nutter/spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/7/2011 Salisbury, Maryland Salisbury Crematory 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD Signature of Funeral Service Licenses 21801 MEMORIAL CHAPEL JOLLEY 23a. Part 1. Enter the disease, or complications that o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause or Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy funeral director, Be 25. Was case referred to medical 26. Place of Death (Pheck only one) examiner? 2 🖺 Hospital: 1 Tes Certificate; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Aatural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Ai completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of ca 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robins William MID 200

State Registrar DHMH 17 Rev 7/2009 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month a M Kathleen M. O'Boyle 2011 6:00 February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 18141 Marksman Circle, Apt. 104 Olney Montgomery Social Security Number If Under 1 Year 8. Date of Birth (Month, Day,) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 1 M 2 TF Min. Hours 214-78-6142 **Director** 53 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pine. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 X No 01ney Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18141 Marksman Circle, Apt. 104 20832 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Public Health Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Jerome Leary Rosemary Patricia McNamara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17204 MacDuff Avenue, Olney, MD 20832 Mary Patricia Leary/Sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 3/5/11 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 22. Name and Address of Facility.
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses Spring,MD 20901 23a Dart T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiomyopathy yrs Medical Due to (or as a consequence of) **Examiner** End-Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a sthe burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death 2 XNo detached 9 Unknown ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျှ Other: 2 5 No 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Nesidence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred 1 🖺 Natural 5 Pending 2 Accident 1 Yes 2 No the f Investigation within 24 hours after des

To the Funeral Director

Completed filled in by th Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifyipg Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) Feb. 28, 2011 D21340 dress of person who completed cause of death (Item 23a) (Type, Print) Raymond Bass, 3941 Ferrara Drive, Wheaton, MD 20906 MD

State

Registrar

31. Date filed (Month, Day, Year)

MAR

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Chris Edwin Olson Month March 6 5:48 AM M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Westminster Carroll Dove Hospice House 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Aug. 17 7. Age (In vrs. last birthday) Funeral TXTX M 2 ☐ F 217-56-2189 Director 45 1965 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant if item 27 is marked other than "natural", or items 23a or 28a-f sho up or other traumatic event, the Medical Examiner must be notified at ury or or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Rockwell Terrace 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Business Consultant Maryland Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roger Edwin Olson Barbara Rankin LeGore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Olson (mother) 6925 Sunset Drive. Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once, cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Smithsburg Crematory 3/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford PA Funeral Home MO1612 106 East Church St. Frederick MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition hypercolcz Medical resulting in death) Examiner x 6 e a sive Sequentially list conditions Examiner cause. Enter Underlying ed by the attending physician and detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Day Linknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N**o Hospital Other: 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 綅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number 14626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40504 501 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 08394 RegistrayFND#25perMD, 3/2/11; FWW, McCc Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Elrod AKA George Pratt III Physician/ 2⁴, February 2011 10:33 P™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11305 Commonwealth Drive Apt. T2 Montgomery Rockville Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 6. Sex 1 X M 2 □ 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. Director 1272771942 OkTanoma 68 444 42 9240 Usual Residence of Decedent shov 10b. County 10a, State be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Rockville Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11305 Commonwealth Drive 20852 United States Apt. T2 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American Indian Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Officer US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Ray Pratt, Jr. Ruth Hopper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Meredith Lynn Elrod/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 02/28/2011 National Crematory Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service dicens 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner Gangrene of Leg l Year Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Peripheral Vascular Disease 5 Years attending physician and for use as the burial-t To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Diabetes Mellitus II Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 L Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure, Coronary Artery Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Cardiomyopathy, Chronic Renal Insufficiency 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 🔀 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After to in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral Completed filled Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title certifier 29d. Date signed (Month, Day, Year) 0005/113 30. Name and address of person who complete d cause of death (Item 23a) (Type, Print) fire #600 M. Sch MD 10400 annestry 31. Date filed (Month, Day, Year) Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 24, 2011 Year Pirir Concepcion Cos 5:30а м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Burtonsville 4c County of Death Montgomery Sanctuary of Holy Cross Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗙 M 2 🗆 F Months Days Hours Min. Delenth 8 ay 19983 Guartremala 27 **Director** none Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director MD Montgomery Takoma Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
Guatemala 8519 Glenview Avenue #101 20912 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, et Guatemalan Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 White 1 X Yes 2 No If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Delivery Bestway Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Marcial Cos Poror Maria Pirir Noj 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Catalina Chitay Culajay, 8519 Glenview Ave.#101 Takoma Park,Md20912 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cemeterio Montufa 20a. Method of Disposition 3/5/2011 20c. Location - City or Town, State San Juan, Sacatepe-quez, Guatemala permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Enemoval from State 4 Donation 5 Other (Specify) Signatur PHNabel Ades RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ with mels disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Dain to for as a consequence off ne attending physician and led for use as the burial-resit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Month Year 1 Yes 2 L 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has performed' 1 Yes 2 No . Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 1 Tes 2 No ᅆ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. прleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2-25-00069829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tehseen R. Naqvi, Ballemine Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registra-PMEND#9+20bper:INF,3/11/11,BW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Polly Sue Perry Day 28, Physician/ Month February 2011 1:50 a™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Silver Spring Montgomery . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Mississiff or Foreign Hours March Day, Year) 192 83rs 428-38-2817 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 11621 New Hampshire Ave. 20904 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 White 1 ☐ Yes 2 H No Specify: If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Completed Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Rusiness Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant Retail Sales other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of permit. Page 1 and 2 should be fi Department of Health and Mentai Important: If item 27 is marked any injury or other traumatic ev once. David Hutchins ည Laura Forester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Perry/Son 1800 R Street, NW, #409, Washington, DC 20009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven Cemetery 1 ★ Burial 2 Cremation 3 🗷 Removal from State March₁ 4 Donation 5 Other (Specify) East Providence, 21. Signature of Funeral Service Licenses Francis defress collins Fu 500 University Blvd. Funeral Home d. W., Silver MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Advanced COPD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been sinned by the attending to the standard of t attending physician and for use as the burial-tr nsit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease, Dementia, Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed : 2 No 1 Tes Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living
Other (Specify) examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 🗗 No ္ခ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D53367 Feb. 28, 2011 cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, #117, Silver Spring, MD 20902 30. Name and address of person who completed a Shyamsundar Rajan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature MARO1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Olimpia Perez-Santiago Physician/ February 2011 3:15 a^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death 3107 Moore Lane Kensington Montgomery 8. Date of Birth
(Month, Day, Year
March 10, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2X F Days Months Hours Min. **Director** Puer<u>to Rico</u> 580-80-5890 100 Yrs 1910 Usual Residence of Decedent Show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland and and the Maryland sattent of Health and Mental Hygiene.

And Condant, If liem 27 is marked outher than "natural", or items 23a or 28a-f sho ordant; If liem 27 is marked outher than "natural", or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Montgomery Kensington 1 Yes 2x X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3107 Moore Lane 20895 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Yes 2 X No If Yes, Give 1 ☑ Yes 2 ☐ No Specify: Puerto Rican White 3 → Widowed 4 □ Divorced Specify: Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Store Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jose Perez-Flores Ramona Santiago-Soto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Rodriguez/Daughter 3107 Moore Lane, Kensington, MD 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 St Cremation 3 Removal from State 2/28/11 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring,MD 20901 Achard L Hates 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Congestive Heart Failure vrs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year n signed by the a Ild be detached f Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has performed? After this certificate I Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: ၉ 1 Tyes 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending (Month, Day, Year) within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41173 Feb. 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #301 Martha Saavedra, MD 10301 Georgia Avenue, Silver Spring, MD 20902

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signatu

State of Maryland / Department of Health and Mental Hygierfe Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month FEBRUARY 25, 2011 **Physician** LEONARD WALLACE PRESBERRY 6:45 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE MANOR CARE - RUXTON TOWSON 8. Date of Birth (Month, Day, Year) JULY 21, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X**) M 2□ F 215-40-2208 1944 MARYLAND Director Usual Residence of Decedent 10c. City. Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 XYes 2 No Director **MARYLAND** HARFORD **EDGEWOOD** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or UNITED STATES 816 MT. VERNON COURT 21040 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼ Yes 2 □ No If Yes, Give Year or Dates: 1965–68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritat Status Black, White, etc. 1 ☐ Never Married 2 X Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT VA HOSPITAL is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUSSELL SYTORIA PRESBERRY HARRTETT REBECCA COLLINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 MT. VERNON COURT, EDGEWOOD, MARYLAND 21040 TAMARA PRESBERRY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If its
any injury or of 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CLARKS UNITED METH 03/05/11 BEL AIR, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. att Commen 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Immure Acquire **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner MNAiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Obstructive Due to (or as a consequence of): Physician/Medical Box (23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 dunknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Aatural 5 Pending investigation To the Hosping.
within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Osler Drive Languar we 31500 HIRPARA

State Registrar 31. Date filed (Month, Day, Year) NAR 0 2 201

32. Registrar's Signature

A back

Physician/

Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.

Baltimore, Maryland 21215-0036

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29b. Signature and

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resulting in death) Last	Due to (or as a consec	uence of):				
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🔲 Ectop	ic pregnancy (specify)		23d. Date of de Month	elivery Day Year
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				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)		
1 Yes 2 X No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 \(\square\) Nursing I	Home 5 🕅 Residence	6 Other (Spe	cify)
27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact	ory, office	28f. Location (Street a City or Town, Sta		ural Route Number,
(Check 2 L Medical Exam	sician: To the best of my know iner: On the basis of examinationse Practioner: To the best of m	n and/or investigation,	in my opinion, death occurred	at the time, date and place	ce, and due to the	cause(s) and manner stated

State Registrar

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31. Date filed (Month Hay, 0

30. Name and address of person who completed cause of death



23a) (Type, Print)

29c. License number

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29d. Date signed (Month, Day, Year)

February 27, 2011

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	Examin	er			ive street and number)					Location of Dea	ath	41	c. County of D		
-	Funeral		5. Social Security No		. Sex 7. Ac	je (In yrs. la	ast birthda		Bethe ler 1 Year	If Under 24 H	s. 8, Date of 9	nith_	Montgo 9.		7 De (State or Foreign
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with	s 23a nust b	Funeral	5817 Wy	ngate Di	3				20817			Ur	nited S	tate	ès
Maryland 21215-0036 2 should be filed within 72 hours after death		by	11. Marital Status 1 Never Marri 3 Widowed		12, Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.					spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		14. Race - A Black, W W Specify:		
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4 68760 sertificate be	as the	Med	IF FEMALE:												
Box 6	To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.		23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	ıl death	3		у			23d. Date of Month	delivery Da	ay Year
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Division tall or Attendings after death.	I Director	Certificate:	3 Suicide 4 Homicide	6 Could no determine	t be 280 Bloco of Inju	ury - At ho c. (Specify,	me, farm,				28f. Location (City or To			Rural Ro	oute Number,
PolluckiMathlew Division of Vii the Hospital or Attending Physic in 24 hours after death.	the Funera	Medical	(Check 2	☐ Medical Exa	hysician: To the best of miner: On the basis of e urse Practioner: To the	examination	and/or in	vestigation, i	n my opinio	n, death occurre	d at the time, date	and plac	e, and due to t	he cause	
To t	To t		29b. Signature and t	title of certifier	he N	M		25	9c. License	3102	7	29d. D.	ate signed (Mo	onth, Day	y, Year) ZOU
			A O L	301EN	o completed cause of d	D OL	D 6	e, Print)	3 TON	N RD	Bett	125	A M	1	20814
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08401 State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2240 2011 Carol Anne Patt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 🗆 M 2 🕱 F Months Days Hours Director 102-54-2995 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time 27 is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 U.S.A. 2217 Washington Avenue, Apt. #103 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 🗓 Never Married 2 🗆 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5**+ Cataloger Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward D. Patt Mercedes M. Bancroft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercedes Patt - Mother 1975 Lake Road, Hamlin, New York 14464 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💆 Burial 2 🗌 Cremation 3 🗶 Removal from State Beechwood Cemetery 02/26/2011 Kendall, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \) \(\text{X} \) No Month Pregnant at time of death Year ed by the a 1 ☐ Yes 2 ☑ 9 ☐ Unknown g Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛛 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 X DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural Accident 5 Pending s after death. Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0060920 1 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, JUNOVE RUDDER ino 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. Pritchard Pau1 11,25 A M Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Willomic Funeral Security Number . Age (In yrs. last birthday) If Under 24 H 8. Date of Birth 9. Birthplace (State or Foreign Month, Day ^{Year} 19<u>57</u> 1 🔀 M 2 🗆 F Months Days Hours Director 214-68-5969 54 Jan. Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2128 Silver Goose Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. Completed by 1 Never Married 2 X Married If Yes, Give 1 Yes 2 X No Specify: white 3 Divorced 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) shipping clerk publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Pritchard Mary Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen D. Pritchard wife 2128 Silver Goose Rd., Cambridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Dorchester Mem. Park ☐ Donation 5 ☐ Other (Specify) 2/28/11 Cambridge, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ HEPATOCZLULAR disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been sinned by the attending to the state of the state o the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year ed by the a detached f 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(\begin{align*}
 \text{Other (Specify)}
 \] ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praction or 1.1 the cause of the course (Check d at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) 33 31. Date filed (Month, Day, Year) State . Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 08403 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death

2.30 M Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ginger Cove Health Center Annapolis Anne Arundel Funeral Social Security Number 6 Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 12 9. Birthplace (State or Foreign 251-56-6622 1 M 2 A 98 Months Days Hours Director Nov. 1912 South Carolina Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 10c, City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 🗌 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? 4000 River Crescent Drive 21401 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 XXIVo Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes. Give Specify: White XX Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John T. Roddey, Sr. Eliza Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Post/son 313 Old Kings Highway Downington, PA Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Naval Academy Cemetery 1XXBurial 2 Cremation 3 Removal from State 3/8/2011 Annapolis, Maryland 4 Donation 5 Other (Specify) Sign eral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line erval Between Immediate Cause (Final t and Realing Pnysician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Inijury Due to (or as a consequence of): Exami the Hospital or Attending Physician: Te law equires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Pregnant at time of death 5 Other (specify) Month Day Year 2 10 Unknown detached 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ge 2 s rould be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificale! performed' 1 ☐ Yes 2 ☐ No director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident 1 Tes 2 No Investigation 2 Accider
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Marical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) CL 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12/1 RG HTFOOT Lor Registrar's Signature ear) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

۱.	For State Registrar	State of Maryland / Department of Health and Maryland / Certificate of Death	16
1.	Decedent's Name (First, Middle, Las)	T

			1 - State Registrar		Cei	rtificate of Deat	th	Reg	J. No.	
	DI		1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death
3	Physici /Medi		RUTH	M. YEAGEF	}	PRICE		arch 1	0. 2011	7:00 A M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Location	on of Death		4c. County of Dear	th
			803 Dellwood D	rive		Fall	Lston		Har	rford
	Funeral		5. Social Security Number 6. Sex	76 -		If Under 1 Year If Und Months Days Hour	's Min. (Date of Birth Month, Day, Y	(ear) 9. Bin	thplace (State or Foreign ountry)
	Director		217-07-0771	M 2MF 92	Yrs.		6/	2/191	8 Per	nsylvania
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, 7	Town or Lo	ecation				10d. Inside City Limits
	Maryl f eho	ŏ	MD. Harfo							1 ☐ Yes 2 🛣No
	28e-	ect	10e. Street and Number	ru		Fallstor	1	100	g. Citizen of What Co	nuntry?
	with Se or	<u>ā</u>	803 Dellwood D	mirro		2104	10			i i
	ne 2:	era		2. Was Decedent Ever in U.S.	13.	Was Decedent of Hispanic			United S	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Iteme 23e or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at ODGE.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexi 1 ☐ Yes 2 X No Speci	can, Puerto Rica	n, etc.)	Black, Whit	e, etc. Vhite
0	72 ho	Completed	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occupation	nant of warding	16	6b. Kind of Business	
215	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done during m DO NOT use retired)	nost of working			
21	gien gien er th	ĕ	12	6		Teacher		E	lementar	y School
nd	al Hy al Hy I oth	Be (17. Father's Name (First, Middle, Last)			18. Mo	other's Name (Fil	rst, Middle, Ma	iden Sumame)	
yla	Ment Ment arke	2	Juluisa	Yeager		E	Emilii	Z_{\bullet}	Baczk	com
Maryland	and and is m		19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street and Num	mber or Rural Ro	ute Number, (City or Town, State, .	Zip Code)
	and ealth m 27 her tr		Dale R. Price	(Son)		Dellwood I		Fal	lston, N	D. 21047 Town, State
Baltimore,	ges 1 r of H if ite or otl		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Re			sition (Name of matory or other place)	March	12,	c. Location - City or	Town, State
Ë	Pa tmen tent: Jury		' 4 ☐ Donation 5 ☐ Other (Specify)	Carr	oll	Cremation	2011	H	ampstead	l, Marylan
3al	permit Depar Impor any in once.		21. Signature of Funeral Service Lidense	· 1 - 1	<u>-</u>	2. Name and Address of Fa	T- U			Funeral
	005 e 0		11. Juliana	x / will		Iome, P.A.			ille, Ma	
	Physician /Medical		23a. Part1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each live.	3/2	er the mode of dying, such	as cardiac or res	spiratory arres	t,	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequer	ice of):	\$*				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. Due to (or as a consequen	ice of):					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events							
oʻ	exec an an rial-tr		resulting in death) Last	Due to (or as a consequen	ice of):					
68760,	te be ysicia ne bu	/Medical								
	ntifica ng ph as th	led	IS SERVICE.			_				
.O. Box	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknowh	ac. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3[Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Δ.	es that igned b be deta	by Pt	Part II. Other significant conditions con	tribut g to deatt out not resulting	ng the u	nderly g caus given in Pa	irt I.	23e. Did toba	cco use contribute to	the cause of death?
of Vital Records,	quires n sign	d b	A ITENIS	20100000	thirt	NT 1138	ASR	1 🗌 Yes	2 □ No 3 □ P	robably 4 Unknown
00	s been s should	Completed	Congerst	YE HOWET	F	2xx/2 =		24a. Was an	24b. Were au	utopsy findings available
Re	The lav	шо	7,000.			0,,00,00		autopsy performe 1 ☐ Yes 2	prior to death?	completion of cause of
tal	ysicien: The is certificate hidirector, page	O)	25. Was case referred to medical			26 Pis	ace of Death (Ci		No 1 Tes	2 □ No
<u>></u>	ysici is cer direct	To B	examiner?	ospital:	/Outpatier	Othor	Nursing Home	-2	ce 6 ☐ Other (Spe	cifv)
101	g Ph ter thi		27. Manner of Death	1	b. Time of			-	injury occurred	
0	ath. r: Af ne fur	atic	Natural 5 Pending investigation	(, 52) . 52.)	injury	M 1 Yes 2	□No			
Division	s after de s after de el Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospitel or Attending Pr within 24 hours atter death. To the Funerel Director. After it completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Phys Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or in	n occurred at the time, date vestigation, in my opinion, o	and place, and death occurred a	due to the cau t the time, date	se(s) and manner as and place, and due	s stated. a to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	(non on		29c. License numbe	5476	290	I. Date signed (Mont	h, Day, Year)
,	VO.		NIVIMANA	WIIIV)		700	1100		MOLLON	10,201
	10.		30. Name and addiess of pers 1 who	pleted cause of death (Item 23	ва) (Туре,	Print) Pal	LOV	上川	An MI	10,04
			MILIMIX	120077 1	00	O DECENT	KU	rall	21002 14	1 TINI

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) MAR 1 6 2011

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		1 - For State of Maryland / Department of Mary	artment of Health and M tificate of Death	-	ene 2011	08405
Physic		1. Decedent's Name (First, Middle, Last) Anna Rebstock		2. Date of Death	y ^{Day} 6 2011	3. Time of Death 11:22 P M
Med Exam			4b. City, Town, or Location of Death Riva	1 CDT ddi y	4c. County of Death	
Funera Directo		5. Social Security Number 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 00/24/1	9. Birth	place (State or Foreign
land show d at	tor	Usual Residence of Decedent	ation		,30 c,p,	10d. Inside City Limits
the Mary or 28a-f	Funeral Director	Maryland Anne Arundel Riva 10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	1 🗆 Yes 2 🛣 No
eath with ems 23a r must b	unera	3030 Pike Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21140 /as Decedent of Hispanic Origin? (Spec	Ū	Jnited Stat	tes
laryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ted by F	1 Never Married 2 Married 1 Yes 2 No	Yes, specify Cuban, Mexican, Puerto R Yes 2 No Specify:		14. Race - Ameri Black, White, Specify: Whi	etc.
1215-I thin 72 ho ane. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Waitr	ent's Usual Occupation ind of work done during most of workin NOT use retired)	g 16	bb. Kind of Business In	
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam prote.	To Be (17. Father's Name (First, Middle, Last)	18. Mother's Name Trini UN	(First, Middle, Maid JKNOWN	Food Serv	71ce
re, Maryla t and 2 should be thealth and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number or Rural	Route Number, Cit		Code)
imore, M Page 1 and 2 s Tent of Health ant: If item 27 ury or other tra		20a. Method of Disposition 20b. Place of Dispos	atory or other place)	ate 200	c. Location - City or To	
Baltimo permit. Page Department of Important: If any injury or once,		4 Donation 5 Other (Specify)	matory 2/28 Name and Address of Facility Geor		dgewater,	
mo sa ≡ e o		29 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	73 Solomons Island	l Road, E		MD 21037
Pnysician/ Medical		Snock, or neart failure. List only one cause on each line.	ure			Approximate Interval Between Onset and Death
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YILGI ING Tysician: The Nis certificate I director, pag		25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Check of	V		
ding Phy th. After this funeral o		27. Manner of Death 1 Inpatient 2 ER/Outpatient 28a. Date of injury 1 Natural 5 Pending 2 Accident Investigation	3 □ DOA 4 □ Nursing Home	d. Describe how in	6 Other (Specify)	
al or Attendia safter death.	Certificate:	2 ☐ Accident		f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
To the Hospital or At within 24 hours after of To the Funeral Direct completed filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 1 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 2 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurrence (Check one) 3 Certifying Nurse Practioner: To the best of my knowledge (Ch	ation in my opinion, death occurred at the	a time data and pla	and due to the one	00/0) and manner stated
To the virthing committee that the committee that t		29b. Signature and title of certifier The A Fange of M. N.	29c. License number	29d. I	Date signed (Month, E / 28/2011	
210	ΙÍ	30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	they Homenan	là m	1. 2140	/
Stat Registra	ie ar	31. Date filed (Mown, Day, Year) MAR 01 2011 32. Registrar's Signature	Med		1 2 10	,

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eduardo Rivera, Jr. March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 087-52-4847 Days Months March Day Year 1958 Director New Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Washington County Hagerstown 1X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral 12817 Little Elliott Dr. Apt 8 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ò Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1X Yes 2 □ No Specify: Puerto Rican "natura!", Completed 3 - Widowed 4 - Divorced Hispanic other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Disabled 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eduardo Rivera, Sr. Jacinta Roman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Rivera-daughter 12817 Little Elliott Dr. Apt 8 Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of injury or 1 Burial 2 X Cremation 3 Removal from State St. Michael's Crematory 3-8-2011 East Elmhurst, NY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern BLvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hyper 120 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chronic Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury sician and burial-transit that the death certificate be executed abolic that initiated events resulting in death) Last Due to (or as a consequence of been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery in the past 12 months? Pregnant Unknown Pregnant at time of death Dav Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 ုင Other: 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending Accident Investigation 1 🗌 Yes 2 🔲 No ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number DU60396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C ct HID ARID 31. Date filed (Month, Day, Year) State Registrar's Signature MAR 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes N 8 L N 7 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02/24/11 ERVIN TROY RUE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **FORCESTED** 714 CLARKE AVE. 20COMOKE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 07/22/57 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. VIPGINIA 1□M 2□ F 43 229-29-2400 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 →Yes 2 No POCOMOKE WORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 714 CLARKE AVE. 21851 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOIS CROPPER KENZY RUE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAPNE RUE, SISTER P.O. BOX 25 OAK HALL, VA 23416 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ↑5 ☐ Other (Specify) ZION CEMETERY 02/28/11 HITHENE, VA 21. Signature of Full eral Service Licenses 22. Name and Address of Facility COOPER & HUMBLES FUNERAL CO., INC., ACCORAC, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MELLITUS TYPE 4 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 250 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Iken 27 Is marked oth any lipiny or other traumatic event once.

death items

filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Director

Funeral

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Completed

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Physician/Medical Completed Be Certification: To

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The law requires that the death certificate be executed I physician a s the burial-1 attending ph for use as th the signed by t 1 be detach page 2 should peen Jas this certificate Physician: After t or Attending death. within 24 hours after death
To the Funeral Director: .
completely filled in by the f Hospital

State Registrar

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29a. Certifier

29b. Sitana

844 100

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

03-01-2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature MAR 0 1 2011 MELLINE

Marks

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 25,27,28a-f, per me,g915 5-17-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar N814N9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 4 FEBRUARY 26917 10:20 AM REESE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1<u>960</u> 1 🗆 M 2 🗶 F Months Days Hours June 24, Ohio **Director** 50 351-56-9423 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States 2406 Ellsworth Way Unit 1B permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Allied Services Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosalie Smith Raymond Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 Ellsworth Way Unit 1B, Frederick, MD 21702 Rosalie Reese / Mother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) Stauffer Crematory 2/28/2011 Frederick, Maryland 21. Signature of Funeral Service License Stauffer Funeral Home 22. Name and Address of Facility ▶ 1621 Opossumtown Pike, Frederick, MD 21702 tra 23a Part 1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart faiture. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ aneutitie disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed NPPROVED BY Due to (or as a consequence of): CERTIFICATION Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deal 4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year signed by the at the detached for Unknown 9 Unknow signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 2 No Yes Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending unknown 2 🗆 No Unknown M within 24 hours after death To the Funeral Director. Investigation 6 Could not be <u> 1986</u> Motor vehicle accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Unknown Unknown Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Cortifying Nurse Practioner: To the best of my kn wiedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year) ac W d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 5 Robert Kaufmahn 9th 5+ 300 Frederick, MD 21701 West 31. Date filed (Month, Day, Year) State Registrar's Signature 20 FEB 2 8 escent. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 2 2:20 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Arnold FutureCare 9. Birthplace (State or Foreign Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 6. Sex 7. Age (In yrs. last birthday) **Funeral** New York Min. 1 ★ M 2 □ F Hours 91 Yrs 053-16-2133 09.1920 Director Feb. Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director Anne Arundel Severna Park 1 🗌 Yes 2 💢 No MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA Funeral 21146 493 DeRussey Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever In U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1941 ş 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 1945 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Oil Company Business Executive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henrietta Holland ၉ Roland Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 493 DeRussey Drive Severna Park, MD 21146 Loretta Reid / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other pla ebruary 28, 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Crownsville, MD 2011 22. Name and Address of Facility
Barranco & Sons, P.A. 21. Signature of Funeral Service Licenses Severna Park Funeral H Severna Park, MD 21146 495 Ritchie Hwy. 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to or as a consequence of): it any leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗆 No Director: After this certificate 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be examiner? Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Manner J eath 28c. Injury at work?
1 Yes 2 No injury latural 5 Pending within 24 hours after death. To the Funeral Director: A Investigation Accident 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifie Name and address of person complet 25 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Blanche E. Stock 12:20 P M February Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Heritage Harbour 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country)Tennessee 1 🗆 M 2 🔀 F Days Hours Min. Sept 4 Months 91 Yrs. 218-20-1264 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State 10d. Inside City Limits 10c. City, Town or Location Director Bowie MD Prince George's 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 USA 3117 Belair Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Nidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Silas Estep Cornelia Bailev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dinah L. Reid/Daughter 10711 Harry Heth Road Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 03/02/2011 Crownsville, MD 21. Signature of Furieral Service Licens Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ty one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir physician and the burial-transit that the death certificate be executed thmia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the should be detached 9 Unknown q I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

Of the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗖 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ali 02-28-2011 20070693 MI de water colony 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHBOOB Annabolis SYED Syle 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR 01 2011

Box 68760

P.O.

Records,

Vital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 eer Physician/ 1145 Ar les e b Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Arnold 116 Howard Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Yo Months Days Hours 1 X M 2 - F Country) Maryland 82 217-24-6285 Yrs **Director** 1928 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director Arnold MD Anne Arundel 1 Tes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a Funeral 21012 USA 116 Howard Avenue within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, was becedent Ever in 0.5.
Armed Forces?
1 ∑ Yes 2 □ No 1945—
If Yes, Give
Year or Dates. 1964 Black, White, etc. 6 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11 Construction Superintendent Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Margaret Morris Charles Vernon Spicer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Howard Avenue Arnold, MD 21012 Nancy P. Spicer / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 03 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Society) cemetery, crematory or other place) Crownsville,MD MD Veterans Cemetery 2011 21. Signature of Juneral Service Livensee 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, P.A. Severna Park Funeral Home Severna Park, MD 21146 Severna Park, art 1. Enter the disease, or comp shock, or he int failure. List only of eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Prioscherotie Immediate Caus (Final disease or convition Pmysician/ 15× A5-9 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29c. License number 29d. Date signed (Month) Day, Year) 1K

DHMH 17 Rev 7/2009

State Registrar ause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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/Medic Examin		4a. Facility Name (If not institution	n, give street and number)			4b. City, Town, or	Location of I		4c. Cour	nty of Death	h
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Funeral Director		5. Social Security Number 218-01-3376	6. Sex 7. Ag 1	98	ast birthday) Yrs.	Months Days		Min. (Month, D	ay, Year)	Col	ryland
land ow	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
he Mary 28a-f sh	Director	Maryland Wash	ington	Kno	xville	10f, Zip Code			10q. Citizen	of What Co	1 ☐ Yes 2 ☑ No
with t		620 Weverton	Road			21758				S.A.	
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and 2 lealth m 27 l			livan/son		1			Boonsbo:			1 21713 Town, State
uges 1 nt of h : If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation				sition (Name of matory or other place				•	
nit. Pa artme ortant injury		4 □ Donation 5 □ Other (S	~ ~ / /	Bro		LLe Cemet 2. Name and Addre			uffer	Funer	le, Maryland
Dep Imp		1 (Class	Whela))	76	06 Old N	ationa				ryland 21713
Physician /Medical		23a. Part 1 Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a. / (AC	71 (V)	2 He	er the mode of dyf	ig, such as c	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
Examiner			Due to (or as								
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):						
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fo the Hospital or Attending Physician: The law requires that the death certificate be expuring a hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 🗆 Feta	Ideath 3[☐Ectopic pregnanc☐Other (specify) _	y		23d.	Date of de Month	livery Day Year
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical (29a. Certifier 1 Certifyle (Check only one) Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examina	owledge, deal ation and/or in	th occurred at the tinvestigation, in my	ime, date and opinion, deat	d place, and due to the the time	ne cause(s) an e, date and pla	d manner a ice, and du	as stated. e to th <i>e</i> cause(s)
To th withir To th comp	Me	29b. Signature the fittle of certifie	Max 100	Mad	ECTI	29c. licens	se number		29d. Date si	ned (Mon	th, Day, Year)
1.1		30. Name and address of person	who completed cause of	death (Iter	n 23a) (Type,	Point) Aug	706	of Hores	5/)//	5/747
分ーン Sta	te	31. Date filed (Month, Day, Year)		rar's Signa	ature (a ne	115/0	I HITCON	(ccere)	M C	1016
Registr	ar	MARS	2011		A. A	Section 1					

DHMH 17 Rev 1/2001

11-01688 Stacy Summers Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	F	l- For State Registrar				Certif	icate o	t Dea	atn				eg. No.		
Physicia Medical Examin	n/	1. Decedent's Name Stacy Al	e (First, Midd len Su	le,Last) MMETS		-					2	Date of Dea Month March 1, 2	Day Ye	ar	3. Time of Death 1449 hrs
		4a. Facility Name (i Howard Cou			d number)				y, Town, or I umbia	Location o	of Death		4c. County Howard		
Funeral Director		5. Social Security N 403–15–1		6. Sex	2	(In yrs. last 8	birthday) Yr	Mor	nder 1 Year	_	er 24Hrs. Min.	8. Date of Bir 08/05,	th(MM/DD/YYY 1972	Y) 9. Birl Foreig Co	hplace (State or n untry) KY
Maryland 28s-f shuw any 1 at once.	_ <u> </u>	Usual Residence of 10a. State PA 10e. Street and Nu	10b. County York	:	1	oc. City, To Sprin		ve	Zip Code			1	0g. Citizen of V	∕hat Cour	10d. Inside City Limits 1 Yes 2 No
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or iter	Fune	11. Marital Status 1 XXNever Marrid 3 Widowed	4 Div	larried Armo	e Year	No	lf `	Yes, spe	ecify Cuban	Mexican specify:	, Puerto R			te, etc. Whi	
1215-0036 Id be filed within 72 hours after featal Hygiene. narked other than "natural", event, the Medical Examiner	Completed by	15. Decedent's Ed Elementary/Seco 12	ondary (0-12)	Colle	ge (1-4 or 5+	,	during n	nost of v	ial Dccupati working life. Operat	or or	use retire	d) 	Manufa	ctur	
21215-0036 Jud be filed within 7 I Mental Hygiene. I marked other than cevent, the Medica	ပ္တိ မ္က	17. Father's Name Harold A								Kath	erine	Abney	Maiden Surnam Kathy	Abn	
	٩	19a. Informant's Na Anna Mai)		8626	Map	ole Gr	o ve		ral Route Nur Spring	OT OVC	, PA	17362
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic.		20a. Method of Dis 1 X Burial 2 4 Donation 5	Crematio	pecify:	val from State	20b. Place Belinc	ne Cen	ther pla			03/0	Date 09/2011	1	ΚY	
Balt permit Depart Impor injury	-	21. Signature of Fu	m	Bla	K I		3 31	1 B	roadwa	ay Ha	anove	r, PA			
Physician (Wedical)		23a. Part I. Enter th failure. List on Immediate Cause (ly one cause	on each line.		ne death. Do	not enter	the mod	ie of dying,	such as c	ardiac or i	respiratory arr	est, shock, or h	eart	Approximate Interval Between Onset and Death
Examiner		or condition resultii	ng in death)		as a conseq	uence of):									
	Examiner	Sequentially list co if any, leading to in cause. Enter Under (Dispass or injury t	nmediate erlying Cause hat initiated	C.	as a conseq										
760, icate be executed physician and the burial - transit	EX EX	events resulting in		d											
8760, ifficate be en ag physician ts the burial		UNPENDED IF FEMALE: 23b. Was decedent		23c. lf	yes, outcome	e of pregnan				75			23d. Date of		/ Day Year
Box 687 he death certific the attending p	Physician	past 12 months	5?	4	ive birth regnant at ti Inknown	me of death	2 F	etal dea other (S		Ectopio	c pregnan		Month		Jay 1 eal
P.O. I res that the signed by the detache	ব্ৰ	Part II. Other signi	ificant condi	tions contribut	ing to death I	but not resu	Iting in the	underly	ing cause g	iven in Pa	art I.			_	the cause of death? pably 4 Unknown
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. In the Funeral Directur: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Completed			_									osy rmed?		topsy findings available completion of cause of
Vital Recc ysician: The lan his certificate ha	8	25. Was case referexaminer?	_	Hospital: 1	Inpatient	t 2 🗸 EF	VOutpatier	nt 3			(Check or	· · · · ·	Residence 6	Othe	r
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Division pital or Attent ours after death teral Directur: filled in by the	Certification:	3 Suicide 4 Homicide	6 Cou	ild not be 28e.	Place of Inju	-	e, farm, stre	eet, facto	ory, office b	uilding, el	- 1	or Town			ral Route Number, City
Division To the Hospital or Attent within 24 hours after death Th the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1		Physician: To the aminer: On the b	e best of my asis of exami ner stated.	knowledge, ination and/	death occu	urred at ation, in	the time, da	te and pla , death oc	ace, and d	lue to the cau the time, date	se(s) and mann and place, and	er as stat due to th	ed. e cause(s)
	W	29b. Signature and	a	}	UL	ر			29c. Licens				29d. Date sig		nth, Day,Year)
15H0-10		30. Name and addr Patricia Aro	nica-Polla	ak MD. As	sistant Me			900	W. Baltin	nore St	reet, Ba	altimore, M	D 21223		
Sta Registi	ate rar	31, Date filed (Mon	th, Day, Year, MAR Q	4 2011 3	2. Re (strair)	Signature	1	A. A.	V						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien & U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, Physician/ 2011 9:35 A. February Charles C. Stup Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick <u>Walkersville</u> Glade Valley Center If Under 1 Year If Under 24 Hrs 8. Date of Birth '. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔼 M 2 🗆 F Months Days Hours Country) 0770971920 **Director** 217-32-5037 90 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🎦 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21702 6802 Sundays Lane · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) agriculture farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Martz Raymond R. Stup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6802 Sundays Lane, Frederick, MD 21702 Pauline E. Stup/wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot remeted crematory or other place)
Faith United Church
of Christ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 03/02/2011 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 10 year Medical Due to (or as a consequent e of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burlal-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death been signed by the a should be detached f Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Yes_ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 🗌 Yes 2 🗌 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work 1 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature d title of cartifier npleted cause of death (Item 23a) (Type, Pri 80. Name and 1475 filed (Month, Day, Year, 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 28, 10:47 P ^M James Albert Smith, Sr. February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Lusby 289 Overlook Drive 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Min. Maryland 1 💢 M 2 🗆 F 212-20-7797 85 Yrs. Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 ☐ Yes 2 No MD Calvert Lusby 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral United States 289 Overlook Drive 20657 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🗶 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White and Mental Hygiene. 3 Divorced 4 Divorced Completed Year or Dates. WW II the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Assistant to the Vice President B & O Railroad 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o Anna Margaret Herline Edward Ernest LaGrande Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 289 Overlook Drive, Lusby, Maryland 20657 19a. Informant's Name/Relationship (Type, Print) Mary P. Smith - Wife other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 03-04-2011 Solomons, Maryland Our Lady Star of the Sea 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rausch Funeral Home, P. A. P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Ons and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the furneral director, page 2 should be detached for use as the burial-transit Deen Vein that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 🗍 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending work? 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 79920 March 1, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Michael Brooks, M.D. 110 Hospital Rd., Suite 111, Prince Frederick, MD 20657 10+1 31. Date filed (Month, Day, Year) 32. Registra s Signature State MAR Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:00 am Rhoda Siegel Medical February 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York 1 🗆 M 2 🎗 F Months Days Hours Director 85 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland sant, If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Prince George's 1 🗌 Yes 2 🗓 No Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6717 Longridge Drive 20706 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel William Cohen Dorothy Kuperstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Siegel - Spouse 6717 Longridge Drive, Lanham, Maryland 20706 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department Important: It any injury or 4 Denation 5 Other (Specify) Judean Memorial Grdns 02/27/2011 Olney, Maryland of Funeral Service Lic Signatu 22. Name and Address of Facility Hines-Rinaldi Funeral home, Inc. <u>11800 New Hampshire Ave., Silver Spring,</u> MD 20904 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) hronic Medical Due to (or as a consequence of Examiner Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of, if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed death? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ြို Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 68049 com 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Garroll 701 31. Date filed (Month, Day, Year) State MAR O 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Irving SCHENKER February Physician/ 7:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Kensington Woodland Assisted Living 8. Date of Birth Jan. 16 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 💢 M 2 □ F **Funeral** New York <u>577-12-957</u>1 88 Director Usual Residence of Decedent 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No Kensington Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20895 3618 Littledale Road #218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1

Yes 2

No Black, White, etc. þ 1 Never Married 2 X Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: 3 - Widowed 4 - Divorced Year or Dates. WW II Completed 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Al Hygiene od other t Accounting Comptroller Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ൧ Bella Max Schenker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 638 Gatestone Street, Gaithersburg, MD 19a. Informant's Name/Relationship (Type, Print) Paul Schenker, Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 X Burial 2 Cremation 3 X Removal from State King David Memorial Garden 03/02/2011 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June al Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St. NW. Washington, 20012 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardiac Arrest
Due to (or as a consequence of): Medical resulting in death) Examiner Ischemic Cardiomyopathy Sequentially list conditions, Due to or as a conse uence of: Examine cause. Enter Underlying Coronary Artery Disease attending physician and I for use as the burial-trynsit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Congestive Heart Failure Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached t Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Renal Failure this certificate has ral director, page 2 autopsy performed? 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Kother (Specify) Assisted 1 ☐ Yes 2 ☐xNo 1 Inpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Living Certificate: Natural 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifig +1 February 28, 2011 D 53691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3200 Tower Oaks Boulevard, #110, Rockville, MD M.D., Ajay Reddy 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20^{Year}1 Jeffrey Lynn Straight 10:15AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Friar Tuck Way Ocean Pines Worcester Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Age (In vrs. last hirthday 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 1 🗆 KM 2 🗆 F Hours 50 232-04-2218 **Director** 2/24/1960 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 Friar Tuck Wav USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 XMarried Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", Completed 3 Widowed 4 Divorced Je filed wh...
Mental Hygiene.
So other than "natu...
The Medical Ex Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Jeweler Jewelry Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, should be file and Mental ? is marked o Eugene Straight Betty Seese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Peggy Straight / wife Friar Tuck Way, Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garden of the Pines 3/3/11 Ocean Pines, MD 21. Signature of Jureral Lery ce Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ Exsanguentin Medical resulting in death) Examiner Self induced lactain to neck 30 mm Sequentially list conditions, Duri to for es a considerere of cause. Enter Underlying Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and-trar Due to (or as a consequence of) physician a sthe burial-t Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician; The law requires Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral a 28a. Date of injury (Month, Day, Year)
2 26 2011 Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1
Natural 5 Pending injury work? 1 ☐ Yes 2 🕱 No Circular Saw Accident 930 9 Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Frim Tunkway Seril N Homicide determined Garage @ residence Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature ertifi 1450492 30. Name and address sperson who completed cause of death (Item 23a) (Type, Print)

Chris Smarr D. DME 100 E Carroll St. Salishy NrIS Date filed (Month, Day, Year) 32. Degistrar's Signature State MAR 0 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 🎧 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** February 27,2011 5:45 A^M IVA JEAN SOMERS /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Tawes Nursing Home Crisfield Somerset 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🂢 F Director 220-16-9364 19,1926 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1√Yes 2 No Director Crisfield Maryland Somerset 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 14. Race - American Indian, Black, White, etc. 125 Richardson Avenue 21817 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Je filed wit.
*al Hygiene.
*ar than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 12 should be filed w h and Mental Hygier 7 Is marked other tt Loan Company Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Lawson Annie Fleetwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:s Department of Health ar Important: If item 27 Is any Injury or other trau Leslie Pruitt (Son) 59 Richardson Avenue -Crisfield, MD21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □Cremation 3 □Removal from State 4 Donation 5 Other (Specify) Asbury Cemetery 3/2/2011 Crisfield, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HME Mary Bern Bradshaw Pruitt 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic ancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☑No 3☐ Probably 4☐Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 5 Pending investigation Injury To the Hospital or within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Hall Hislusay aumburata. Vyau 31. Date filed (Month, Day, Year) 32. Regintrar's Signature State MAR 0 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ a^{M} February 2011 7:18 Α. Soucy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 1 🗆 M 2 🕸 F Hours March 20, 87 Yrs. Director 006-14-0454 Usual Residence of Decedent f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director or 28a-f sl notified 1 Yes 2 No MD Gaithersburg Montgomery 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ò "natural", or items 23a o edical Examiner must be Completed by Funeral 419 Russell Avenue, Apt. 20877 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc 1 X Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Commerce Travel Administrator Be 18, Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) ပ Mildred Ann White Gilmore Soucy Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John N. Leebrick/Personal Rep. Gaithersburg, MD 20877 Russell Avenue, Apt. 515; 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/1/11 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 527515 disease or condition resulting in death) days Medical Due to (or as a consequence of): Examiner 5 days acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-trapel To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ► No Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 2 9 Unknown detached as been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Yes 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) agol Medical Center Drive, Fockville, Maniland Daphne Keshishian 31. Date filed (Month, Day, Year) State WAR 02 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 Phillis Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital <u>Takoma</u> Park Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🛭 F Months Davs Hours Min. (Month, Day, Year, 08/20/1922 New York Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Director 1 X Yes 2 □ No MD Silver Spring Montgomery 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20906 USA 15320 Pine Orchard Dr 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist Beauty Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rebecca "Unknown" Nathan Palay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blake Smith / Son Olive Branch Dr. Silver Spring MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place)
Judean
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/25/2011 <u> 01ney, MD</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Edward sagel 1091 Rockvil Funeral Direction Inc. Le Pike Rockville, MD 20852 **Blake** Kurt 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician disease or condition resulting in death) monic Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Tyes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending vithin 24 hours after death.

o the Funeral cirector Aformpleted filled in by the fu 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month [0 D6383 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20912 7600 Carroll Takoma Park, Padma Chirumamilla M.D. Ave. 32 Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Ma	aryland / Depa	artment of H	ealth and N	lental Hy	Same.	011	08424
		Decedent's Name (First, Middle, Last)		timodic or D	- Cutil	2. Date of De	Reg. No.		3. Time of Death
Physici		Patricia	041			Month	Day	Year 2011	1:07 A M
Medi Exami		4a. Facility Name (if not institution, give street and number)	Silve	4b. City, Town, or	Location of Death	Februar		inty of Death	
		3100 Fairweather Ct.		01ne					
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	g. Birth	place (State or Foreign
Director		065-28-2112 1□M2XIF	77 ^{Yrs.}	Months Days	Hours Min.	(Month, Da 12/22/	1933	Cour	New York
D M	١.	Usual Residence of Decedent 10a, State 10b, County	40- Cit T-						40 Library Charling
yland -f sh ed a	cto	Toa. State Tob. County	10c. City, Town or Loc	cation					10d. Inside City Limits 1 X Yes 2 □ No
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ith th	Funeral Director						10g. Citizen		ntry?
ath w	nue	3100 Fairweather Ct.	erin IIS 13)	20 Was Decedent of His	0832	cify Ves or No-	14.5	USA Race - Americ	een Indian
or ite	by F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 M	1	f Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)		Black, White,	
urs afte		3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 X No	Specify:		Spec	oify:	White
2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupa			16b. Kind o	f Business In	
in 72 e. " man "	별	Elementary/Seconday (0-12) College (1-4 or 5-	life DI	kind of work done du O NOT use retired)	inng most ot worki	ng			
with ygien t, the		12	Н	omemaker				Own Ho	ome
filed tal Hy d oth	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Surna	ame)	
first yisting ZIZIO-0000 should be filed within 72 hours after death with the Manyland and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at		James Morrissev				Clara	Nemer	off	
shoushous and raum		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ig Address (Street ar	nd Number or Rura	l Route Numbe	er, City or Town	n, State, Zip	Code)
ire, Marylanta ZIZIS-0030 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		<u>Leslie Silverman / Daughter</u> 20a. Method of Disposition		<u> Fairweat</u>					
or of Fig.		1 🗆 Burial 2 🛣 Cremation 3 🛣 Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place) [Date	20c. Location	on - City or Te	own, State
mit. Page 1 mat. Page 1 partment of portant: If i y injury or ce.		4 Donation 5 Other (Specify)	National (5/2011	Fal:	ls Chu	rch, VA
Definition Permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee	Eg	Name and Address Iward Sago 191 Rockv	s of Facility e1 Funera	al_dired	ction]	Inc.	
		25a/Part 1. Enter the disease, or complications that caused						4D 208	52 Approximate
		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	the death, bo not ente	i the mode of dying	, such as cardiac c	i respiratory an	1631,		Interval Between Onset and Death
Pnysician/ Medical		disease or conditiona. Metast	atic Lung	Cancer					
Examiner		Due to (or as a	consequence of):						
	Jer	if any, leading to immediate Due to (or as a	consequence of):						
nted d ansit	ari	cause. Enter Underlying Cause (Disease or imjury that initiated events c. Pulmor	ary Conges	stion Resi	niratory	Arrest			
be executed sician and burial-transi	Ĕ	resulting in death) Last Due to (or as a	consequence of):	,	,				
cate be executed physician and sthe burial-transit	dical Examiner	d		Cardiac	Arrest				
tifical ng ph		IF FEMALE:							
eath certifica attending p	ian/	23b. Was decedent pregnant 23c. If yes, outcome o	Fetal death 3	Ectopic pregnancy	,			Date of deliv	
deat the at	Physician/Me	1 Yes 2 No 4 Pregnant at g Unknown	time of death 5 ∟	Other (specify)				Month	Day Year
Attending Physician: The law requires that the death certifica ar death. are death. etcor. After this certificate has been signed by the attending ply the funeral director, page 2 should be detached for use as the funeral director.		Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e Did to	nhacco use ci	ontribute to t	he cause of death?
signe	d by	Diabetes Mellitus, Hyper		, ,					bably 4 X Unknown
requi	ete		cension						psy findings available
has law	Completed	GIST Tumor				24a. Was autop	osv	prior to co	empletion of cause of
n: The la ficate har, page		Anemia of Chronic Disease 25. Was case referred to medical	2			1 Yes	2 X No	1 Yes	2 🛣 No
sicial certi irecto	m	examiner? Hospital:		Othor	ce of Death (Check				
Phy r this eral d	e: To	27. Manner of Death 28a. Date of injury	t 2 ER/Outpatien 28b. Time of	28c. Injury	4 L Nursing Ho	me 5 🕰 Resid 28d. Describe h			/)
nding ath. :: Afte	icat	1 X Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injury	work?			,,		
Atte er dec ector by th	Certificate:	3 Suicide 6 Could not be	y - At home, farm, stre	eet, factory, office				mber or Rura	l Route Number,
tal or rs after al Dir	0	building, etc.	(Specify)			City or Tow	n, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 X Certifying Physician: To the best of m (Check 2 ☐ Medical Examiner: On the basis of examiner:							
thin 2 the I the I	Me	only one) 3 Certifying Nurse Practioner: To the b	est of my knowledge, d	leath occurred at the	time, date and plac	e, and due to th	e cause(s) and	manner as st	tated.
		29b. Signature and title of certifier Carol a. Melada, M	40	29c. License	number		29d. Date sig	ned (Month,	∪ay, Year)
12				D457	84		02/2	4/2013	
		30. Name and address of person who completed cause of dea			о т 1	MD 007	70.7		
Sta	te	Carol A. Neroda, M.D. 735 31. Date filed (Month, Day, Year) 82. Registrar	O Van duse 's Signeture	n Kd. #32	<u>u Laurel</u>	MD 207	0./		
Registr		MAR 0 2 2011	p. pas						

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed	- Pn	Balt Permit
within 24 hours after death.	y: M	Depar
To the Funeral Director: After this certificate has been signed by the attending physician and	ei ei im	Import
сотрleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	cie dic nin	any in

Physicia	n/	For State Registrar 1. Decedent's Name (First, Middle, Last) ROBERTO ADACHI SASAKI	•	partment of Health ertificate of Death	2. Date of Dear	Reg. No. th 3. Time	4 2 5 of Death				
Medic Examin	er	4a. Facility Name (if not institution, give street and num. Shady Grove Adventist H	ospital	4b. City, Town, or Location Rockv111e	·	4c. County of Death Montgomery					
Funeral Director		5. Social Security Number 219-79-3689 Usual Residence of Decedent 10a. State 10b. County 6. Sex 1 ☒ M 2 ☐ F	7. Age (In yrs. last birthday 81 Yrs.	Months Days Hours		1929 Country) Pe					
ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral Di	Armed For	ces?	S 10f. Zip Code 20841 3. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No-	1 🗀 Nog. Citizen of What Country? Peru 14. Race - American Indian, Black, White, etc.	∕es 2 K No				
than "natural", o	Completed by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	es. 16a. Dec (<i>Giv.</i> life.	1 X Yes 2 No Speci bedent's Usual Occupation we kind of work done during me DO NOT use retired)	Peruvian	Specify: Asian 16b. Kind of Business Industry Dentistry					
marked othe	as l	17. Father's Name (First, Middle, Last) Yoshiteru Ada	chi	18. Mo	ther's Name (First, Middle, M	Maiden Surname) Sasaki					
Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exanonea.		19a. Informant's Name/Relationship (Type, Print) Erika I. Adachi/ Daughte 20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	r 1420 State 20b. Place of Discemetery, cr Metropol		Road, Boyds, Date 3/1/2011	City or Town, State, Zip Code) Maryland 20841 20c. Location - City or Town, State Alexandria, Virg	ginia				
Impo any ir		23a. Part 1. Enter the disease, or complications that coshock, or heart failure. List only one cause on each	aused the death. Do not e h line.	10 East Deer P	ark Dr., Gai	thersburg, MD. 2	nate Between				
edical and parial-transit principle and prin	edical Examiner	Sequentially list conditions, large cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	r as a consequence of): PSIS r as a consequence of): LTI LOBAR r as a consequence of):	PREUMONIA PARKINSONS)						
the attending posterior	~ I	in the past 12 months?	ant at time of death 5	Control of the contro		23d. Date of delivery Month Day	Year				
sen signea by ould be detac	ted by Pl	Part II. Other significant conditions contributing to de		e underlying cause given in Pa		pacco use contribute to the cause of the ca					
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompleted filled in by the funeral director, page 2 should be detached for use as the model of the funeral director. To Be Completed by Physician/Media											
Director: After this or a in by the funeral dire	Certificate: To	25. Was case referred to medical examiner? 1									
to the Funeral Completed filled	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the basi only one) 3 Certifying Nurse Practioner: T	s of examination and/or inv	estigation, in my opinion, death	occurred at the time, date an ate and place, and due to the	d place, and due to the cause(s) and	manner sta				
State		30. Name and address of person who completed cause MARICHU MATAS M		, Print) MOLECULAR D	RIVE SUITE	2 ROCKVILLE	mD				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08426 State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 Day 23 **Physician** 2011 7:50 A Mabel Joyce Stapleton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Apt 112 Frederick 1100 Peach Orchard Lane Brunswick 9. Birthplace (State or Foreign Country)
W.V. Date of Birth (Month, Day, Year) 9/17/1933 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Director 233-45-7203 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Frederick Brunswick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö items 23a 21716 USA 1100 Peach Orchard Lane Apt 112 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 0 1 □Yes 2**X** No Specify. White 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "ary or other traumatic event, the Pages." Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julius Vincent Sigler Lottie May Lucas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other traionice. 1100 Peach Orchard Lane Apt 110 Brunswick MD. Beatrice Holler, Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 2/28/2011 Lovettsville VA. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barbare John T Williams Funeral Home, Brunswick MD. 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial minutes /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit and Due to (or as a consequence of). physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 □ Yes 2 ★ o 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No disease 1 ☐ Yes

The law requires that the death certificate be executed Box 68760 P.O. Records, page Vital or Attending Physician:

of

Division

certificate | funeral director. After this To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur

Be

Medical Certification: To

pulmonas 25. Was case referred to medical examiner? 1 Yes 2 XNo

29b. Signajure and title of certifien

27. Manner of Death 1 Natural 5 Pending

2 Accident 3 Suicide 4 Homicide

(Check only one)

29a, Certifie

6 Could not be determined

investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Avenue Brunswick

MD0026890

1 ☐ Yes 2 ☐ No

ay 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gessest 010 OW 32. Registrar's Signature

31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deatr Physician/ William Smith Calvin Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number 9. Birthplace (State or Foreign Country) PA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □**x**M 2 □ F Months Days Hours Min MOV 19 Director 215-20-7124 83 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d, Inside City Limits Director MD Allegany Frostburg 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Honeysuckle Lane Apt. 100 21532 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: permit. Page 1 and 2 should be filed within 72 hours afte. Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exam any injury or other traumatic event, the Medical Exam If Yes, Give Year or Dates WW II 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Union Representative Celanese Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah (Anderson) Smith George Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip 222 Chestnut Ridge Road Grantsville MD 21536 Leanora Green daughte Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Sunset Memorial Park 3/14/2011 Cumberland MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Scarperfiff Ultreral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part /. Enter the distance or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHROMIC TRUCTIVE LUNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Doe to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 9 Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONGESTUR Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 🗌 Yes 2 🗍 No 2 25. Was case referred to medical **Division of Vital** director, æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ြု 1 Yes 2 No 1 ☐ Inpatient 2 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work' 24 hours after death. Funeral Director: Al 1 🗌 Yes 2 🗆 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and matter.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F only one) 29b. Signature and title of certifie MARCH 11 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 BISHOPWALSH ROAD (LUMPERLAND AID 21502 HARUT SIDHUM T 31: Date filed (Month; Bay, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 08628 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011^{Year} MARCH 2:44P CONCETTA JUANITA SARJEANT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. Marwrand Director May 579-78-20**1**6 Usual Residence of Decedent show 10a. State at 10c. City. Town or Location 10d. Inside City Limits Director r 28a-f sh notified a 1 X Yes 2 □ No MD Frederick Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral All Saint's 30 W. Street United States items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or iten edical Examiner n Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Completed by ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Chapman Stephens Hilda I Sarjeant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Knick (personal rep 6508 Ellington Way, Frederick, MD 21703 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parklawn Cemetery 3/11/2011 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Reeney & Basford P.A. Funeral Home 106 E. Church St., Frederick, Maryland 21701 MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pneumonia Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lusease or impury Examine Due to (or as a consequence of): sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No 4 Pregnant Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ≥ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 110 ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 Natural work? 1 ☐ Yes 2 ☐ No after death 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) MO 00063653 March 4, 2011

State Registrar Shawn

Date filed (Month, Day, Year)

MAR 16 2011

DHMH 17 Rev 7/2009

West

400

32. Registrar's Sichature

Seventu Street

Frederick, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar 08429 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Month 3 Millard Henry Sines Jr. Medical 5:30A M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collge View Center Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 XM 2 - F Hours 73 1291 Pay 13 37 Director 214-36-0001 Yrs. COMP) Usual Residence of Decedent show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Frederick Brunswick 1 Kes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 405 Walnut St. 21716 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 ☐**M**No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) well drilling operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Millard H. Sines Sr. Opal Bircher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Millard Sines III (Son) 1058B Arnoldstown Rd., Burkittsville, 20a. Method & Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 Cremation 3 Removal from State Union Cemetery 3/15/2011 on 5 🗆 Other (Specify) Burkittsville, MD ture o License 22. Nona and Addess B. Facilithompson Funeral Home 111 Middletown, MD 21769 ter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Immediate Gause (Final Onset and Death Ph_sician/ emplication disease or condition resulting in death) / Medical Due to (our s a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of): the burial-transit Vasculan 211 and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month 1 Yes 2 9 Unknown 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 0054636 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Syed

31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G914, 4/11/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancy Lee Siebeneichen March 8, Day 2011 Year 2:55 PMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Glade Valley Nursing & Rehabilitation Walkersville Frederick Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1930 Days Hours Min. June 24, Months 146-26-0991 80 Pennsylvania Director Usual Residence of Decedent show 10b. County 10a. State within 72 hours after death with the Maryland at 10c. City. Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified Maryland 1 🗆 Yes 💹 No Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2514 Underwood Lane 21710 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ģ 1 Never Married 2 Married 2**Y** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2√2 No Specify: Specify: White 3 Widowed 4X Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Community College Microcomputer Lab Manager Be Page 1 and 2 should be filed or ment of Health and Mental Hyon ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev George Clark Smeltzer Agnes A. Sjoholm ^{19arhymm}nt's Name/Relationship (*Type, Print*)

Mynn D. Siebeneichen, daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2514 Underwood Lane, Adamstown, MD 21710 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Smithsburg Crematory Mar. 9, 2011 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg, MD 21. Signature of Furieral Service Licer Keeney and Basford PA Funeral Home M00255 East Church St., Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final NEUMONIA Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Duri to (or as a consequence of If any, teeding to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No signed by the atte Month Day g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> TRANSVERSE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Yes 2 No 1 🗌 Yes 2 🗷 No 25. Was case referred to medical B B 26. Place of Death (Check only one) Other: ျ 1 🗌 Yes 2 🛂 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 24 hours after death.
Funeral Director: After this eted filled in by the funeral dir funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one Signature and title of certifier MA 021936 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 COHNED N DRIVE A.DONECSON FREDERICK 65C THOMAS 10 MA 31. Date filed (Month, Day, Year) MAR 1 6 2011 State Registrar's Sign Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 08431 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Year 10:28AM THERESA ANNE THOMPSON Feb 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 134 Teat Millington Queen Annes Ave. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🛛 F Months Days Hours Min. 215-44-5836 Director 63 Maryland 7-6-1947 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a heafter it is a feature. MD Millington Director Oueen Annes 1 ☐ Yes XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 134 Teat Av Funeral 21651 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 22 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Turner Morris Ivy Illingworth ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur 134 Teat Av. Millington, Marvin Thompson, Jr. / Husband MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/2872011 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry Glenn Burnie, MD 4 ☑ Donation 5 ☐ Other (Specify) DANIELS & Hutchison Funeral Home, LLC. 212 N. Broad St., MIddletown, DE. 1 9700

peath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a process of the proc 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cluse Cluse or injury that initiated events Examine Due to (or as a consequence of): executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical ası attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached o 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page certificate 1 □Yes 2 2 🗆 No 1 ☐Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ope, Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes After this of funeral direction 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Presidence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or within 24 hours after death.

To the Funeral Director: Aft 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

Rm State Registrar

3

29b. Signature

30. Name and address of

hamberlain MD Maryland Primary Care Group

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

037064

29d. Date signed (Month, Day, Year)

115 Sallitt Dr. Stevensville, MD

6/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMFND#260cerMD3/2/11; BWI, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Feb. 23, 2011 Thomas Trone 9:50a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Sunrise at Fox Hill Bethesda Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 🔀 M 2 🗆 F 6/23/1926 PA. 210-12-8540 Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Poolesville 10a. State 10d. Inside City Limits Director MD Montgomery 1 ☐ Yes 2 No 17039 Tom Fox Avenue 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20837 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? 1 No 1946 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Wine Project Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname)
Carrie Elizabeth Williamson ပ Stanley John Trone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David Trone/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🔲 Cremation 3 🖾 Pernoval from State Greenmount Cem. 2/26/2011 York, Pennsylvania 5 Other (Speciff 4 Donation 21. Signatur of Fungral Service PHITTP AT SERVICE, P.A. Columbia Blvd.Silver Spring Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 1 WK Physician/ Aspiration pneaumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Severe dementia Sequentially list conditions, if any, leading to in hediate cause. Enter Underlying Examiner Duis to (or as a consequence or) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day ed by the 9 Unknown eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 K No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) Feb. 24, 2011 29b. Signature and title of 29c. License numbe D0057896 M.D. 10215 Fernwood Road Bethesda, Md 20817

Registrar

State

32 Registrar's Signatur

David W.Hirshfield M.D.

2011

31. Date filed (Month, Day, Year,

MAR 01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth M. Wolff February 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 859 Inverrary Court Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/21/1925 **Funeral** 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Hours 86 Washington. **Director** 579-20-8661 D.C Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 859 Inverrary Court 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced White Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fred W. Holzberger Elizabeth Burwinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Page 1 and 2 sh Department of Health a Important: If item 27 is David A. Wolff/ Husband 859 Inverrary Court, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 3/3/11 Crownsville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 🗓 No Certificate: To 4 Nursing Home 5 K Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending injury 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) $\neg U$

Registrar

State

Box 68760

P.O.

Records,

Division of Vital

133 Defense Hwy., Ste. 109, Annapolis,

MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Richard A. Bernstein,

MAR 0 1 2011

31. Date filed (Month

State

Registrar

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

of Vital

Division

FT. WASH MD20744

32. Registrar's Signature

Distantion the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 02/20/2011 Physician/ Ella Louise Warner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Queen Anne Hospice Queen Anne Centreville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 6. Sex 1 □ M 2 💁 Country) Days Min 02/14/ 58 Director Yrs VA 216-56-0556 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Oueen Anne Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 South Commerce St USA 21617 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after obpartment of Health and Mental Hygiene. 1 ☐ Yes 2 No Specify. Specify: Black ould be mood and Mental Hygiene.
Is marked other than "natural" 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food traumatic event, the 12 Dietary Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Lee Stewart Eddie Turner, Jr. and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 405 South Commerce St. Centreville, Melvin Warner (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/25/11 Greensboro, MD Coker Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility MD A. Brince 855 High St. Chestertown Bennie Smith FH shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death una unes Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician appage 2 should be detached for use as the burial. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 | Yes 2 2 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No → Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 No Yes the Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 No 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending injury work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Praction of To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one) 29b. Signature and title of certifie. 29d. Date signed (Month, Day, Year) 0 10 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

GUNDMAN

0.0

31. Date filed (Month, Day, You)

2540 Centracillo

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21617

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 18, 2011 KEITH WENDELL WILSON 10:03 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL CECIL ELKTON Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 1 **X** M 2 □ F Months Davs Hours Min. MARYLAND Director 213-66-6001 53 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No CECILTON MD CECIL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 122_WILSON STREET 21913 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRENCHER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည ORIE WILSON DAISEY ANN BRAXTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOHEMIA AVE. CECILTON, MD 21913 ROMEKA W. BLACK / DAUGHTER 116 N. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTER, MARYLAND CHESAPEAKE CREMATION 02/26/2011 21. Signature Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 fellows 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ cardiac arrhythmia runs Medical resulting in death) Examiner Hyperkalemia Sequentially list conditions, Examiner if any leading to immedia cause. Enter Underlying Acuk Renal that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of) Vomitha Physician/Medical) eeks the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD, CHF, COronary To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, disease 1 ☐ Yes 2 ☐ No 3 MProbably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 No Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 29d. Date signed (Month, Day, Year) 18,2011 170316 MO Februsy Wame and address of person who completed cause of death (Item 23a) (Type, Print) Kton, MD 2192

Registrar

68760

Box

P.O.

Division of Vital

32. Registrar's Signature

			Plea	ase Type or Pri								08437		
			For State Registrar	State of M	-		rtment of <i>tificate of</i>		d Mental H	ygien Reg. N	Life -	U0437		
	Physicia	ın/	1. Decedent's Name (First, Middle JOHN				2. Date of D	Death	Day Year	3. Time of Death				
ming	Medic Examir		4a. Facility Name (if not institution	П	4b. City, Town	or Location of De			Day Year 25, 2011 Ac. County of Dea	10:04A M				
majoral .	Funeral		FREDERICK MEM 5. Social Security Number		A.L. e (In yrs. last birth	day)	FREDI		rs R Date of F	2irth	FREDER			
H	Funeral Director		264-76-3643	1 X M 2 D F				o. Date of Birti						
	fand sand sand sand sand sand sand sand s	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation	<u> </u>				10d. Inside City Limits		
	ne Mary or 28a-1 notifie	Director	Maryland Frede:	rick	New Win	dso	r 10f, Zip Code		Citizen of What C	1 ☐ Yes 2 🛣 No				
	n with the same is 23a courst be	Funeral	9801 McKinstry	Mill Road		Tor, Zip code	21776		109. (U.S.				
36	I and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. The Health and Mental Hygiene. The marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ģ	11. Marital Status 1 □ Never Married 2 🛣 Man 3 □ Widowed 4 □ Divorced	ver in U.S. No		as Decedent of Yes, specify Cu	Hispanic Origin? ban, Mexican, Pue No Specify:	14. Race - American Indian, Black, White, etc. Specify: TTb 4 + 0						
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land ;	should be filed vand Mental Hyg r is marked other raumatic event,	To Be	17. Father's Name (First, Middle, L George Millard		8. Mother's Name (First, Middle, Maiden Surname) Frances Mary Roberts									
	and 2 should Health and N tem 27 is ma other trauma		19a. Informant's Name/Relationship (Type, Print) Kathleen Williams / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 9801 McKinstry Mill Road, New Winds											
imore	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other	3 Removal from State		, crema	atory or other p	tory 3/	Date 3/2011		Location - City or	Town, State , Maryland		
Balt	permit. Depart Import any inj once,		21. Signature of Juneral Pervice L	icensee	1	RO.	Name and Add BERT E.	ress of Eacility DAILEY	& SON FU	JNERA	AL HOMES	, P.A.		
	۸		23a, Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line	the death. Do no						EDERICK.	MD 21701 Approximate Interval Between		
J	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ny san	consequence of	3960	4 (63)					Onset and Death		
There's	Examiner	er.	Sequentially list conditions,	b. ———										
	d ansit	Examiner	if any, leading to immediate Cause (Disease or iinjury that initiated events C											
	be executed rsician and burial-transit	- 1												
9289	eruncate ding phy se as the	/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy									
Division of Vital Records, P.O. Box 68760	To use nowputer or Attended Proprioran: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Ectopic pregna Other (specify)				23d. Date of delivery Month Day Yea						
ds, P.C	quires that en signed k ould be det	ted by P	Part II. Other significant condition	ons contributing to death bu	ut not resulting in	the und	derlying cause	given in Part I,		23e. Did tobacco use contribute to the can be a like to the can be a li				
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ivisio	after dear Directors In by the	Certificate:	2 Accident Investig 3 Suicide 6 Could i 4 Homicide determi	t, factory, office	M 1 Yes 2 No factory, office 28f. Location (St. City or Town				ral Route Number,					
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	within To th		29b. Signature and title of certifier	~		<u> </u>	29c. Licer	se number	3, 2, 1, 2, 3, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5,		ate signed (Month			
	0		30. Name and address of person v	who completed cause of de	ath (Item 23a) (Ty	pe, Prir	nt)	.\			///			
	Stat Registra	σ	31. Date filed (Month, Day, Year)	1 201 32. Registral	's Signature	1	branklar							

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VIOLET VIRGINIA WACHTER 11:20 AMM February 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Citizen's Nursing Home Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗌 M 2 🕱 F 3/317, Pay Year Mary land Director 220-09-7050 Usual Residence of Decedent ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 □ No MD Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1900 Rosemont Avenue 21702 items "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates ll Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Health Care 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental | မ Clinton Monroe Schwartz Beulah Virginia Myers it. Page 1 and 2 should by rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Zickafoose/ Daughter P.O. Box #474, New Oxford, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Smithsburg Crematory 2/26/11 Smithsburg, Maryland 21. Signature of Funeral Pervice Lights of 22. Name and Address of Facility Dailey rket St Robert E. Dail 1201 N. Market & Son Funeral Homes, P.A. Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, in dry, leading to minimum character cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by 2) No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 **No** Other: 1 Inpatient 2 ER/Outpatient 3 DOA 41 Nursing Home 5 Residence 6 Other (Specify) 27. Manner o eath . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred tural work? 1 Yes 2 No 5 Pending injury Accident Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year MT 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lvle David Wilkerson Sr. 5143AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death isbur 04 iconico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Šex 1 ₹ M 2 ☐ F 9. Birthplace (State or Foreign 52 Days Min Hours 0171971959 226-64-1890 Mary land **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item. ortant. If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director New Church Virginia Accomack 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 23415 28224 Pitts Creek Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: white Completed 3 Widowed 4 K Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) agriculture farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Ann Townsend Philip R. Wilkerson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 7240 Ayres Lane Rd., Snow Hill, MD 21853 Lyle Wilkerson II/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 2/28/2011 Salisbury, MD 21. Signature of Fundral Service Licensee 22 Name and Address of Facility Holloway Funeral Home Professional Associaiton Mu Vine St., Pocomoke City, MD 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ason Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any because Enter Underlying Examiner Dain to for earla nonsequence off Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the s 9 🗌 Unknown cate has been signed by pege 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence & Other (Specify) Coada No No ٥ 1 🗌 Yes 1 🗀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manyter of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 63199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOHRA 910 EA STERN (HOLE 40GENH 12 SALISBULY ND, 2184 egistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#25,27,28a-f, perME, G915,572372011, ws Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 26 2011 Physician/ 0431 A M Joyce Lent Worley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours September 5 Mary Land "1922 88 Director 225-22-0234 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Calvert Prince Frederick Maryland 1 🗆 Yes 2 🖹 No 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20678 United States 5490 Hallowing Point Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Registered Nurse Δ Be 18. Mother's Name (First, Middle, Maiden Surname) Ada Crockett Dehart 17. Father's Name (First, Middle, Last) Edward Phillpe Lent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7833 C. Street Chesapeake Beach Maryland 20732 Shawn Humberd - daughter March 1 2011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Funeral Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeyal Service License 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE Physician/ HRUNIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to his median cause. Enter Underlying Cause (Disease or linjury that initiated events tus Examiner The to for as a consequence of PARTICIPATION APPROVED BY MEDICAL EXAMINER by the attending physician and tached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 1 Yes 2 Leg Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After Natural 5 Pending Accident 2-23-2011 4:00 P M 1 Yes 2 No Investigation Subject tripped and fell 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5490 Hallowing Point Road, Prince Fredrick, Maryland filled in by determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 305 Princefrederick Md HOSPITALRO 110 MATHUR MUKesH 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 08441 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Beatrice Paula Weissman F_{eb}^{Month} 24, 20_{11}^{Day} 6:40pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8100 Connecticut Ave. #10-10 Chevy Chase Montgomery 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth
(Month, Day, Year)
April 2, **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 042-16-1313 1 M 2 X Days Min. Ct Country) Months Hours **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nand Mental Hyglene. 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Chevy Chase Montgomery 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 8100 Connecticut Ave, USA #10-10 20815 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ð 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 🗌 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Nidowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Karl Hoffman Regina Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kurt Weissman/Son 120 Riverview Ave, Middletown, RI 02842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 2-27-2011 Star of David CEm North Lauderdale, FL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and a for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autonsy performed? Yes 2 X No After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 🙀 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify, funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation within 24 hours after death by the Funeral Director: / completed filled in by the f 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ithin 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie Ō 29c. License numbe 29d. Date signed (Month, Day, Year) D26259 Feb 25,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Ave, Bethesda, MD 20814 Ava Kaufman, M.D.31. Date filed (Month, Day, Year) Registrar's Signature State MAR Registrar

			for State Registrar	State of Ma		partment of l prtificate of l		i wentai Hy	Reg. No.	08442
ı	Physicia	an/	1. Decedent's Name (First, Middle, Last, John Huber Wasi	2. Date of De		3. Time of Death 3:10 p M				
1	Medi Examir		4a. Facility Name (if not institution, give s		4b. City, Town, o	r Location of Dea		4c. County of De		
	Euporal	P	1307 Sarah Drive 5. Social Security Number 6. Sex	7 Age) If Under 1 Year	Silver	Spring s. 8. Date of Bir		gomery	
	Funeral Director		242-22-7728	M 2 D F	(In yrs. last birthday 86 Yrs.	Months Days	Hours Min		y, Year 25	Birthplace (State or Foreign Country) NC
	show dat	١	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I		-			10d. Inside City Limits
	e Mary r 28a-f notifie	Direc	MD Mont	gomery	Sil	Lver Sprin	ıg			1 ☐ Yes 2 🖾 No
	s 23a o	eral	1307 Sarah Drive			10f. Zip Code 2090	14	İ	10g. Citizen of What USA	Country?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Married 2 🛣 Married 3 🗆 Widowed 4 🗆 Divorced		WWII	B. Was Decedent of Half Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, WI Specify: WI	
21215-0036	hin 72 ho ne. than "na ie Medio	omple	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Giv	edent's Usual Occup e kind of work done DO NOT use retired)	during most of wo	orking	16b. Kind of Busines	
1d 2	iled wit Il Hygie other vent, th	8 B	17. Father's Name (First, Middle, Last)	5±	Phy	sicist	18. Mother's Na	ame (First, Middle,	Federal (Maiden Surname)	Government
Maryland	uld be f d Menta narked natic e	2	John Wasilik, Jr.					Violet Th		
Ma	d 2 sho alth and 127 is r er traur		19a. Informant's Name/Relationship (<i>Typ</i> Ann Mary Wasilik/W		I	-			er, City or Town, State,	'
Baltimore,	ige 1 an nt of He t: If iten		20a. Method of Disposition 1 Description 2 Description 3	lemoval from State		ematory or other pla	ce)	Date	20c. Location - City	or Town, State
altin	permit. Pa Departme Importan any injury once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Incenses	•	· · · · · · · · · · · · · · · · · · ·	lls Cemete		1arch 1,	Germantow Home Inc.	
B	2 2 E 6 5		23a. Part 1. Enter the disease, or compli)		<u>00 Univer</u>	sity Blv	d. W. Si	lver Sprin	g, MD 20901
7	Physician/ Medical Examiner	Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Concestive Due to (or as a	= Heart F consequence of):	ailure				Approximate Interval Between Onset and Death
	e death certificate be executed the attending physician and hed for use as the burial-transit	/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a	Fetal death 3	☐ Ectopic pregnant	sy		23d. Date of o	delivery Day Year
s, P.O.	res that the des signed by the a d be detached	d by Ph	Part II. Other significant conditions con Hypertension	tributing to death but	t not resulting in the	underlying cause give	ven in Part I.			to the cause of death?
Division of Vital Records,	Physiolan; The law requires that the death certiful this certificate has been signed by the attending ral director, page 2 should be detached for use a	Completed by						24a. Was a autop perfo	an 24b. Were a prior to death'	autopsy findings available o completion of cause of
/ital	ysician; is certifii director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital:	nt 2 🗆 ER/Outpati	Oth	ace of Death (Che		dence 6 🗆 Other (Spi	
ion of	To the Hospital or Attending Physical Author Attended to the Funeral Director. After this completed filled in by the funeral di	Certificate: T	27. Manner of Death 1	28a. Date of injury (Month, Day,	28b. Time	of 28c. Injury	y at		ow injury occurred	эспу)
Divis	ital or Att		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
:	tne Hosp nin 24 hou the Funer	Medical	only one) 3 Continying Nurse	r: On the basis of exa	ımination and/or inve	stigation, in my opinio	on, death occurred	at the time, date a	ind place, and due to the	e cause(s) and manner stated.
			29b. Signature and title of certifier	d	$\sqrt{}$	29c. License	8920		29d. Date signed (Mor	
	io ,		30. Name and address of person who cor	nnleted cause of dea	(Item 23a) (Type,	Print)			Feb. 28 MD 20770	, 2011
	Stat	0	Surinder Singh, 31. Date filed (Month, Day, Year)		s Signature	200400	way, GI	eemert,		

Registrar

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 08443 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Samuel Joseph Woodrow, Jr. March 2011 12:50 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County Cecil Elkton (Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania Funeral 8. Date of Birth Date of D. ... (Month, Day, Y 1**X** M 2 □ F Months Days Hours Director 185-24-9343 Dec. Usual Residence of Decedent 3a or 28a-f show t be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No Marvland Ceci1 Colora 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b 2544 Liberty Grove Road 21917 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 N

If Yes, Give 1 Black White, etc. 1 Never Married 2 Married Maryland 21215-0036 should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 1950-52 Army 1 ☐ Yes 2XXNo Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Textile Industry Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic o Samuel Joseph Woodrow Sr. Elizabeth McCann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2544 Liberty Grove Road, Colora, Maryland Barbara A. Woodrow / Spouse 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March^{Date} 2. 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 2011 Newark, Delaware Signature of Fune al Socice Livensee 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_{sician/} Onset and Death CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of): ^tExaminer Gequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of): CONGESTIVE To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autonsv 1 ☐ Yes 2 ☑ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 🗗 No 1 Inpatient 2 I ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu ☐ Accident ☐ Suicide Investigation

Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 1,2011 D63 486 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 31 Date filed (Month

STREET, CYTON, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mar 3 Eugene Wilson Robert Sr. 20:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 701 East Fourth Street Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Hours ^{Month, Day} 3^{ear)} 1939 Director 214-36-8942 Yrs. Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cumberland 1 □xYes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 East Fourth Street 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify Completed 3 Divorced 4 Divorced white 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done (life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) construction worker Construction Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) and Mental F 1 and 2 should be fill f Health and Mental item 27 is marked ပ္ George Wilson, Sr. Rosa Mae (Abe) Wilson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 13 Beechwood Dr. Cumberland MD 21502 Rose Greber daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ &remation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 3/9/201 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): transitthe Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contriblyte to the cause of death? 1 ☐ Yes 2 ☐ No 3 👿 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: ျ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural N 5 Pending Accident
Suicide
Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier 星 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAYROMATIS M.B. 1250 2 WILLWBROOK 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiens 18645 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>8</u>, Physician/ February 2011 Kay Wilson 7:03 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1622 Cody Drive Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 M 2 XF June 2, 1981 Country) 29 Yrs. Director 217-96-9034 Usual Residence of Decedent 10a. State the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f si notified MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be with 1 Funeral 1622 Cody Drive 20902 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 14. Race - American Indian, þ Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked None traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Timothy Wilson Beverly Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Beverly Wilson/Mother 1622 Cody Drive, Silver Spring, MD 20902 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If i any injury or conce. 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 3/2/2011 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA <u> 1etropolitan Crematory</u> permit. Signa ire of Funeral Service Licensee rancis J. Collins Funeral Home Inc. \$00 Univeristy Blvd. W., Silver Spring,MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Arteriosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Day Pregnant at time of death the detached 9 Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. Morbid Obesity 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen Fibromyalgia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy certificate Yes 2 No Polycystic Ovaries 1 Yes 2 No e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifical leted filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗀 Yes 2 XNo Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident 6 Could not be ☐ Suicíde 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F 3 [29b. Signature and title of certific 29c. License number 29d. Date gned (Month, Day, Year) verson who completed cause of death (Item 23a) (Type, Print)
April, MD 121 Congressional Lane, #204, Rockville, Md 20852 Name and address Michael

Registrar DHMH 17 Rev 7/2009

State

E.

WAR 0 2 29

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 18646 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wallace Richardson Willey February 9:49 a M 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester General Hospital Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**x** M 2 □ F Months Days Hours 219-03-6703 88 Yrs Director 25, 1922 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Experience must be notified at MD Dorchester Director Cambridge 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 100 Aurora Street 21613 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: white 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 11 \end{array}$ College (1-4or 5+) plant manager food processing permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important; if Item 27 Is marked other t any injury or other traumatic event, I'll once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Gorman Willey Mary Elizabeth Wallace ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winifred Willey wife 100 Aurora St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemi 4 ☐ Donation 5 ☐ Other (Specify) 3/1/11 Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee WO Ken 700 Locust St., Cambridge, MD 21613 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi and Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

Ody,

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a per PHY State of Maryland / Department of Health and Mental Hygiene 2011 AACO HEALTH DEPT. CMH 1 - For State 2/Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month BARBARA V. WILSON 02 2011 4:50 Medical ta. Facility Name (if not institution, give street an RATRETELD, NURSING, AND REHABLETTATION CENTER Examiner 4b. City, Town, or Location of Death 4c. County of Death CROWNSVILLE ANNE ARUNDEL 5. Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Hours Min Director 219-38-1431 73 MARYLAND 02/11/1938 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10b. County Director 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ANNE ARUNDEI CROWNSVILLE 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 1454 FAIRFIELD LOOP ROAD 21032 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: 3 Widowed 4X Divorced BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. **ADMINISTRATION** 12 CLERTCAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SAMUEL LEBETTER ROBERTA WILSON permit. Page 1 and 2 shoul Department of Health and I Important; If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KELLY BLAIR/BUSINESS OFFICE 454 FAIRFIELD LOOP ROAD, CROWNSVILLE, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date BESTGATE MEMORIAL 1 X Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) 02/25/2011 ANNAPOLIS, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LASTING HELFENBEIN & NEWNAM CREMP. A. 814 BESTGATE ROAD, 22. Name and Address of Facility part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Aspiration Pneumonia Onset and Death Fnysician/ disease or condition resulting in death) 4comonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine rany, leading to immedia cause. Enter Underlying Cause (Disease or linjury e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year detached Unknown 9 Unknown After this certificate has been signed by in funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 2 🗌 No Investigation Accident completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) way of death (Item 23a) (Type, Print) Name and address of person who completed 31. Date filed (Month, Day, Year) FEB 2 State Registrar

			Plea	ase Type or Pri									
			For State	State of M	aryland /		artment of I tificate of I		Mental Hygi	ene2 ()		08448	
			Registrar 1. Decedent's Name (First, Middle	, Last)			uncate of t	Jeauri	2. Date of Death	g. No.		3, Time of Death	
F	Physicia Medio		Mary R. Wool						Februar	Day 23)	Year 20	1) 82004M	
	Examir	ier	4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center Glen burnie 4b. City, Town, or Location of Death Glen burnie								ty of Deat	Arundes	
D	uneral irector		5. Social Security Number 181-28-9936 Usual Residence of Decedent	6. Sex 1 M 2 F 7. Ag	e (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	930	9. Birl Was	thplace (State or Foreign Shington DC	
aryland	a-f show ified at	ector	10a. State 10b. County Maryland Anne	Arundel	10c. City, To	wn or Loc		apolis				10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
with the M	23a or 28 ist be not	Funeral Director	10e. Street and Number 2305 River Cre	escent Drive	<u> </u>	-	10f. Zip Code	21401	10	lg. Citizen of	What Co	/hat Country? USA	
036 rs after death	from Z71s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 X Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Bla	14. Race - American Indian, Black, White, etc. Specify: White				
215-0 lin 72 hour	han "natu Bedical	Completed		nt's Education st grade completed) College (1-4 or 5	(Give k	NOT use retired)	ation during most of work	king 1	6b. Kind of E	Industry			
Ind 27	ed other t	To Be C	17. Father's Name (First, Middle, L	ast)		Hom	emaker		ne (First, Middle, Ma		-		
Baltumore, Maryland 21215-0036 perrit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Huslene.	7 is marke	_	Howard Clark 19a. Informant's Name/Relationsh Edmund T. Wool	nip (Type, Print)	and I	9b. Maili <u>n</u> 2305	g Address (Street : River C		Drayton Par Route Number, Cor, Annap	-	State, Zic MD 2	21401	
WMOFE, N Page 1 and 2	If item 2 or other t		20a. Method of Disposition 1 ☐ Burial 2 X Cremation		20b. Place	of Dispos	sition (Name of eatory or other place			0c. Location			
Baltur permit. Pag Deportmen	Important: If its any njury or of		4 Donation 5 Other (S ₁ 21. Signature of Funeral Service Li		Balti		Cremato Name and Addres	ry 2/24 ss of Facility Jo	4/2011 : ohn M. Ta	<u>Baltin</u> ylor F			
	2 = # O		23a. Part 1. Enter the disease, or	complications that caused	the death, Do						olis	Approximate	
M	sician/ ledical aminer		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	7 n-8		mox	779			1	Interval Between Onset and Death	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Erner Underlying	b. Due to (or as a	a consequence	e of):							
be executed	within 24 hours after dearn. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a	a consequence	e of):							
e death certificate be		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									ivery Day Year	
S, F.O.	signed by Id be detar											the cause of death?	
necords, The law requires	e has beer age 2 shou	Completed by	Dial	2-24-65			/		24a. Was an autopsy performe	ed2	prior to c death?	opsy findings available completion of cause of	
VICAL F	ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Pla	ace of Death (Chec	1 ☐ Yes 2 k only one)	No	1 🗌 Yes	2 No	
Physic	this of	은	1 Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/0	Outpatient . Time of	3 DOA Othe	4 L Nursing Ho	ome 5 Residence			fy)	
on or anding Pl ath.	r: After ie fune	icate	1 Alatural 5 Pending 2 Accident Investig	(Month, Day		injury	work		28d. Describe how	injury occuri	red		
tal or Attendir rs after death.	al Directo ed in by th	l Certificate:	3 Suicide 6 Could n 4 Homicide determin		ry - At home, i :. (Specify)	farm, stree	et, factory, office		28f. Location (Stree City or Town, S	et and Numb State)	er or Rur	al Route Number,	
he Hospii in 24 hou	he Funer	Medical	(Check 2 Medical Ex	Physician: To the best of a caminer: On the basis of ex	camination and	or investig	gation, in my opinio	 n. death occurred a 	t the time date and r	place and du	e to the c	ause(s) and manner stated	
To t	To t		29b. Signature and title of certifier	y, m	2)		29c. License			Date signe			
44	0.		30. Name and address of person w	ho completed cause of de	eath (Item 23a)	(Type, Pr		Hosp	iter))	mal	6	In Burn;	
R	Stat legistra	٠,	31. Date filed (Month, Day, Year) FEB 2 8	32. Registra	r's Signature	1. 16	arks	1	-	1			

11-01818 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amanda Willey State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 3. Time of Death Month Day March 6, 2011 **Medical Examiner** 2007 hrs Amanda Starr Willey 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) WV Months Days Hours Director 186-64-5186 2 X F 30 Yrs 10/22/1980 1 M Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No Fulton Needmore ultimore, MD 21215-0036

iit. Pages I and 2 should be filed within 72 hours after death with the Maryland arment of Heath and Mental Hygiene.
ortant: If item 27 in answed other than "natural", or items 13s or 28s-f sho per orther traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8385 Great Cove Road 17238 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 2 X No Yes 4 Divorced If Yes, Give Yaar 3 Widowed 1 Yes 2 X No specify: Specify: White <u>≨</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Club 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James W. Willey Vicki L. Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Wille<u>y/Father</u> 8385 Great Cove Road Needmore. PA 17238 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify Pleasant Grove 03/10/2011 Warfordsburg, PA 22. Name and Address of Facility 21. Sign ture of Funeral Service Licenses 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, signed by the atte I be detached for u 1 Yes 2 V No 9 Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribule to the cause of death? ੬ 1 Yes 2 No 3 Probably 4 Unknown pleted this certificate has been a director, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of performed? ✓ Yes 2 No death? Com 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 🗸 Inpatient 2 Other4 Nursing Home 5 Residence 6 Other: ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Subject driver of vehicle that ran off road and FOUND: 1 Natural 5 Pending 1 Yes 2 V No the into a tree 2 🗸 Accident hrs Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Pennsylvania State Road 643, Brush Creek Township, P determined (Specify) State Road 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely with n 24 l Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 7, 2011

HV

State 31. Date filed (Month, Day, Year)

Victor Weedn MD JD

32. Registrar's Signature

el

intenda Cianatura

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 26. 2011 11:50 A M GLORIA MARIE YEAGER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth March Day Year 1931 1 - M 2 - F Days Min 214-28-7223 79 Pennsylvania Director Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 South Market Street Apt. 1B 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Wallace Nelson Grimes, Sr. Mary Catherine Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark S. Yeager / Son 201 South Market Street Apt. 1B, Frederick, MD 21701 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory |3/1/2011 Smithsburg, Maryland 21. Signature of Funeral Service Licensee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Ful 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumaria Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months 1 Yes 2 No Month Day Vear Pregnant at time of death be detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Drabate autopsy perform death? 2 🗌 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DE NO Certificate: To Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident work? 5 Pending 2 🗌 No Investigation Could not be completed filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Umedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-26-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year)

MAR U1

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

Dr- Frederick MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
RegistrateND#23e+24aperMD, 3/3/11; BMW, MoCo 08451 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 22:08 PM ENWARD . Medical 4a. Facility Name (If not institution, give str Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON AdvENTIST TAKOMA PARK MONTGOMERY 5. Social Security Number 577-78-4202 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 XM 2 □ F 40 DISTRICT of Columbia Director Usual Residence of Decedent "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10d. Inside City Limits Director DC 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 1+AWKINS Funeral 8810 US 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) UNEMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Williams SR JACQUINE OUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chery MD 20815 WITE 8810 HAWKINS LN 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 03-04-2011 INCOLN SUITIAND MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE HOUSE OF WILLAMS UPSHUR STREET WASH-DC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying tending physician and or use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 After this certificate has autopsy performed' death? 1 ☐ Yes 2 X No Yes 2 No **Division of Vital** funeral director, 25. Was case referred to midical Be 26. Place of Death (Check only one) examiner? Hospital: ျှ 1 🗌 Yes 2 No Other: 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number D0064024 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACHTCHININA, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 08452 1 - State Registrar AMEND#23a(a)perMD, 3/1/11; BWW, McOCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Legesse Kibret Zerfu Feb. 26, 2011 6:30a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Social Security Number If Under Funeral . Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Months Days Min. Hours Country) Ethiopia **Director** 219-71-7107 58 Usual Residence of Decedent show e 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. I have seen a 12 seen 27 is marked other than "natural", or items 23a or 28a-f show for other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6733 New Hampshire Avenue 20912 Ethiopia 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager United Nations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kibret Zerfu Asthede Kelkaie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tenketem Dessta/Wife 6733 New Hampshire Ave. Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or or Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. Trinity Cem. 3/06/2011 Addis Ababa, Ethiopia 4 Donation 5 Other (Specify) 21. Sign the f Funeral Service Lice see Philip Agentialdi Funeral Service, P.A. Blvd.Silver Spring, Md 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line age Immediate Cause (Final Onset and Death €fiysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): as the burial terms To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate has autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည Other: Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this and completed filled in by the funeral direction. 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manuer of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Pending iniury work? 1 Yes 2 No M Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title 29d. Date signed (N son who completed State

Registrar

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requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/Medic	in the past 12 months?								Month	Day	Year				
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Attencer death	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investiga 6 Could no determin	ot be	Be. Place of	Injury - At h	ome, farm, s	M street, facto		Yes 2	□No	28f. Location	(Street ar	nd Number or Ru	ırai Route	Number.
ital or irs afte ral Dire						, etc. (Specif						City or To	wn, State	=)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2		aminer: O	n the basis	of examination	on and/or inv	estigation, in	n my opinio	n, death c	occurred at	the time, date	and place	nd manner as st e, and due to the (s) and manner as	cause(s) a	and manner stated.
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-	<i></i>		Laurel Regional Hospital	Laurel	Prince George's									
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 579-84-8721 1 → M 2 → F 52 7. Age (In yrs. last birthday 52 7. Age (In yrs. las	If Under 1 Year If Under 24 Hrs. 8, Days Hours Min. Min. Jan	ate of Birth 1959 9. Birthplace (State or Foreign Country) Washington, D.C.									
	and show	ě	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits									
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	with the s 23a or	Funeral D	10e. Street and Number 11504 Basswood Court	10f. Zip Code 20708	10g. Citizen of What Country? United States									
9800-	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	1 Never Married 2 M Married 3 Widowed 4 Divorced Armed Forces? US Army 1 W Ses 2 No 1980 If Yes, Give Feb. 1980 Year or Dates. June 1980	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 🛣 No Specify:	etc.) Black, White, etc. Specify: Black									
21215-0036	vithin 72 h yiene. er than "na the Media	Compl	(Specify only highest grade completed) (Giv	adent's Usual Occupation • kind of work done during most of working DO NOT use retired) rvisor Housekeeping	16b. Kind of Business Industry National Institutes of Health									
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1760	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	ledical Examiner	dical	dical	dical	dical	dical	dical	dical	dical	dical	it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Due to (or as a consequence or):		
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Division of Vital Records,	i ician : The law re certificate has bu ector, page 2 sh	Completed by		1	4a. Was an autopsy performed? ☐ Yes 2 No 1 ☐ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N									
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death only one) 1 Medical Examiner: On the basis of examination and/or inversely one) 2 Medical Examiner: On the best of my knowledge, death only one)	stigation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s) and manner stated.									
	Vorith Con		29b. Signature and title of certifier Herry Wellow MD	29c. License number	29d. Date signed (Month, Day, Year)									
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Perry Weisman, MD Laure Region											
	Stat Registra	•	31. Date filed (Month, Day, Year) MAR 1 7 2011 32. Fegistrar's Signature	all	,									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ALLUISI 2120PM 201 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death Funeral If Under 24 Hrs. 8. Date of Birth (Month, Day, 1 - 30 9. Birthplace (State or Foreign Months Min 2803 Director Usual Residence of Decedent 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 3 ☐ Widowed 4 ☐ Divorced Completed GEMED 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industri (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use setired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 08 BAHIMOR 12 +1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or To permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 N Burial 2 Cremation 3 Removal from State 19-2011 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final-Onset and Death Physician/ (oroneus) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner days may theme Sugrentially list nunditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 3, 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAIRA BILAL , Union Memoria

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Memorial

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 08456 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:45A M James William Archer March 2011 Medical 4a. Facility Name (if if not institution, give street and number)
Baltimore Medical Center Examiner 4c. County of Death Baltimore Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 170-24-6728 1 ☑ M 2 □ F Days Hours Min (Month, Day, Ye Director Pennsylvania 1925 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1X☐ Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21210 USA 847 W. University Pkwy 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Avcher James Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates white 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 □ Divorced Completed 1946 16a. Decedent's Usual Occupation unit 16b. Kind of Business Industry un (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 6 other 1 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic arons 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Blazer Archer Hattie Leo Skidmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alix Shearer - niece 12 Avenue Emile Acollas 75007; Paris, France 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, crematory or other place, 21. Signature 22. Name and Address of Facility State Anatomy Board Mineral Sen Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pheimonia disease or condition resulting in death) melics Medical Examiner MSOMUNA mecks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or es a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) by the attending physician a ached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Pregnant at time of death Dav g Unknown a Unknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Courdionyoput 1 Yes 2 1 8 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? this certificate har ral director, page 2 No Yes 2 LH 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ٥ 1 II Impatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner - Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 1 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

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State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Pute

MAR 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

6201

N

Registrar's Signatu

Charles

29c. License number

DO07063

Batimore

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Mary Maggline Ethridge Boykin 3:51 A. M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Prince Georges Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1944 Funeral Month, Day, Year) 1944 December 16, Min Months Days Hours North Carolina 66 Director 241-64-6958 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fiem 27 is marked other than "nature!" any injury or other traumatic events. 10b. County 10d. Inside City Limits 10c. City. Town or Location 10a. State Director Prince Georges Mount Rainier 1 X Yes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20712 United States 4218 - 29th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Giv Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) nentary/Seconday (0-12) College (1-4 or 5+) Private Family 12th grade Nurse's Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Sarah Thomas Adolphus Ethridge 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4218 - 29th Street; Mount Rainier, Maryland 20712 Camillus Louis Boykin, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 Donation 5 Other (Specify) **Ŧort Lincoln Cemetery** Name and Address of Facility R. N. Horton Company Morticians, 21. Sonature of Funeral Service La Inc.: 600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ANONCBERIN DAMAGE Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RECURNENT Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): HYPOGLYCEMIA Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL (NEUFFICIENCY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 14 Y PERTENSION 24a. Was an PERPINATORY FAILURE performed? Yes 2 AN 2 🗌 No 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner

1 Yes 2 No Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 00043662 March 4/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyce; M.D.; 3001 Hospital Drive; Cheverly, Maryland 20785 31, Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 08458 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month March 20^{Year} Paul W. Braun 1:15 Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Funeral Social Security Number 7. Age (*In yr*s. 49 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country Unk 213-88-5139 1 🔀 M 2 🗆 F Months Days Hours (Month, Day, Director June Usual Residence of Decedent ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Upnor Rd. 21212 USA 12. Was Decedent Ever in U.S. Armed Forces?unk 1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. o, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural". If Yes, Give Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Page 1 and 2 should be or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Upnor Rd; Baltimore, MD 21212 Nancy Braun - wife permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Caus. Final and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner natiti 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury for use as the burial-tran attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be **Box 68760** IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month 4 Pregnant
9 Unknown Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 3 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ၉ 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. e Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred ■ Natural 5 Pending work' Accident
Suicide 1 Tyes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month. Day, Year) BASU 3 HOOG 7817 111 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCAT 1:34 PM 201 Catherine Evelyn Bavis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** AGNES BALTMORE HOSPITAL N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 23, 1911 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 □ XF 99 Maryland 215-22-0345 Apr. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore 1 □Yes X□No Director MD Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1205 Seven Oaks Road 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No 3 ₺ Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Newton Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Kappauf George Stivers ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Seven Oaks Rd., Arbutus, MD 21227 Shirley Adkins - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) Altlantic Crematory Mar.20,2011 Glen Burnie, MD ture of Funeral Service Linessee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to minimal to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ISCHENIL BOWEL Due to (or as a consequence of): Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The 1∐Yes 2 🖔 No 2 🗹 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after decral Director: And 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D

completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 024781 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. GRAMMER MO 1001 PINE Highto ME, 5300, BANGUARE NO ZE-

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month MARCH IVAN Barney 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GENESIS FRANKLIN WOODS CENTER Baltimore
| Funder 1 Year | If Unc Baltimore 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 158-20-8/69 Hours Months Min Director Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Supervisor Housing Authoritu 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, James Barney
19a. Informant's Name/Relationship (Type. Print) Viola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Avandale Ave. Dundalk, MD 21222 Velma Barney - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Stanislaus Cent. 3-18-2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21202 Approximate Interval Between Onset and Death FAILURE THRIVE Immediate Cause (Final 70 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): SYNDROME Examiner MYELODYSPLASTIC Sequentially liet our differentially leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Puneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 24 29c. License number **B** 0061789. 29b. Signature and title of certifier fon Awach inp. MARCH, 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LORPAINE OF AWUAH, MO, 5430 CAMPBELL BLVD; STE 214, BALTIMORE MD 2036 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAR 17 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Blanche Bellamy Month 3 7:07рм 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stell Maris Towson Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 F Months Days Hours Min (Month, Day, Year, 218-18-8902 93 Country) Director TХ Usual Residence of Decedent Show 10b. County at death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD N/A Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1651 E. Belvedere Ave. 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married within 72 hours after Yes 2X No 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐XNo Specify. Specify: Black "natural" 3 XWidowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 7:07 (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) John Hopkins Hospt Housekeeping 12th Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) 2 Louella B. Hill Goliad Sherrills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Granditem 27 Michele Randall-1849 Sulis St. Philadelphia, PA 19141 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, MARCH NationalMem.Pk 3-19-2011 Laurel, MD MD 21. Signature of Fune Service Licensee 22. Name and Address of Facility March F/H North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \(\sum \) Yes 2 \(\mathbb{X} \) No Month Year Pregnant at time of death Day 1 Yes 2 Unknown the Unknown Division of Vital Records, P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: မ 1 Yes 2 X No After this of funeral din 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending the Funeral Director; At mpleted filled in by the fu 1 Yes Accident Investigation 2 🗌 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

comple only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

JUNECIA WHITE, CRNP

31. Date filed (Month, Day, Year)

MAR 17 2011

BELLAMY

BLANCHE

2300 DULANEY VALLEY RD.

32. Registrar's Signature

TIMONIUM, MD 21093

11-01997 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Allan Keith Belcher State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 13, 2011 Medical Examiner 1506 hrs Allan Keith Belche
4a. Facility Name (if not institution, give street and number) Belcher 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital **Baltimore County** Rosedale 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral Hours Months Davs Director 1X M 2 F 2/14/1961 Country) Maryland 50 Vre 216-78-5182 Usual Residence of Decedent 10b. County 10a. State 10c City Town or Location 10d. Inside City Limits 1 Yes 2X No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "oatural", or items 23a or 28a-f shov
injury or other traumatic event, the Medical Examiner must be ootified at once. Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? <u>347 Dark Head Road</u> Α. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year 982-1999 3 Widowed 4 X Divorced 1 Yes 2X No specify: Specify: Š White 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Officer Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar James Belcher Mildred Catherine Hudgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Belcher (Daughter) 708 Worthington Street Spring Valley, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: Bay<u>view</u> Baltimore City, MD Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 23a. Part I. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 23a,27 per me g915 5-2-11 vt attending physician or use as the burial X UNPENDED **AMENDED** or Atteodiog Physiciao: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown cate has been signed by the page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other₄ Nursing Home 5 Residence 6 Other 1 Yes 2 No 28a. Date of Injury (Month, Day, Yea 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Director: d in by the f 5 Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be 24 hours determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Within ? 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Theodore M. King, Jr., MD.

and manner stated

Assistant Medical Examiner

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

March 14, 2011

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien & U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 2011 6:55a M Patricia Brown Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 2 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, \) 1 □ M 2 🖾 F Months Days Hours Min Director 579-54-6891 Yrs 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits 1 ☑ Yes 2 ☐ No MD Prince Georges Capitol Heights 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6928 Walker Mill Road United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Divorced 4 Divorced al Hygiene. I other than "naturs vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event injury or other event injury or other Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed Unemployed 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Thomas Metts Agnes Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2410 Good Hope Rd. #101 SE Wash. DC 20020 Valeta Jones/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Chesapeake 3-12-2011 Beltsville Maryland 21. Si ture Juneral Servic at Len. 22. Name and Address of Facility John T. Rhines Funeral Home LLC 3005 12th Street NE Washington DC 20017 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Congestive Heart Failure Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) s been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypertension, Diabetes Mellitus Type2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has page 2 autopsy performed? Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? the funeral director Be 26. Place of Death (Check only one) Hospital Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) 1 🗌 Yes 2 🖺 No 2 1 Inpatient 2 K ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural iniury 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) R169951 3-11-2011 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) John Hudson-Odoi CRNP 15245 Shady Grove Rd Rockville MD. Suite 130 20850 32. Registrar's signature State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month enovierse Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Conter erstorun Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** '. Age (In yrs. last birthday) 82 8. Date of Birth (Month, Day, NOV 18, 9. Birthplace (State or Foreign Months Min. Year) 1928 212-24-7438 1 🗆 M 2 🛣 F Days Hours **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington Clear Spring 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21722 27 S. Martin St; Box 125 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. <u>\$</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 K No Specify. Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 school lunch worker school system Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fannie Elizabeth Eichelgerger permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. Richard Roman Shirley other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Cook - son 27 S. Martin St; Clear Spring, MD 21722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock art failure. List only one cause n each line Immediate Cause (Final hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir and -transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last physician a s the burial-t Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 TNo
9 Unknown Month Pregnant at time of death Day Year ed by the a detached f 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas page 2 autopsy performed Hospital or Attending Physician: The ☐ Yes 1 ☐ Yes 2 ☐ No 2 7 25. Was case referred to medical funeral director, **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work?
1 Yes 24 hours after death, Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 2 No the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the Certifying Nurse Practioner: To the best of my knowledge, duath cooursed at the time date and place, and due to the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Meritus Medical Center Hagerstown, MD

Registrar DHMH 17 Rev 7/2009

State

Valdmir M. Rakhmanin

2011

MAR 17

31. Date filed (Month, Day, Year)

32 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Wendell Henderson Carr Sr. 20°11 21:47рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fort Washington Hospital Fort Washington Prince George's Social Security Number 6. Sex 1 🖾 M 2 🗆 F Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 10-2-1944 Richmond, Director 237-70-3944 66 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Guilford NC Greensboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 27406 349 E. United States Montcastle Dr. Unit A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 🕅 Married Completed by Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Black If Yes, Give 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Auto Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Henderson Ethbert S. Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 349 E. Montcastle Dr. Unit A, Greensboro, NC 27406 Vaughnetta Hodge Carr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Demoval from State 03-16-2011 4 Donation 5 Other (Specify) Cremation Services Winston Salem, NC 22. Name and Address of Facility Mthavillan Frervice Signature f Funeral Se M01284 VC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death cardiac Physician/ disease or condition resulting in death) arrest Medical Due to (or as a consequence of) Examiner tricular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine s been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Due to (bras a consequence of). per tensio that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day Yes 4 ☐ Pregnant 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 I Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performe 2/ N 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident after death Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12 0631 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 Livingston Road, Fort Washington, MD Karen Dixon, M.D. 31. Date filed (Month, Day, Year) NAR 17 Registrar's Signature State 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ester 05:48 AM 201 Medical lare 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ltimore Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 14, 1933 1 🔀 M 2 🗆 F Months Days Hours Min. 77 Maryland Director 219-28-2111 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Linthicum 1 Yes 2 XNo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 6304 Buckcavey Lane 21090 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n/aTruck Driver Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lycester Ezikel Mary Evelyn Campion Cavey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Walsh / Daughter 925 Deep Creek Avenue Arnold, MD 21012 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park Mar.16,2011 Elkridge, MD Signature of Euneral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition oronary Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed shysician and the burial-transit Exam Tensio that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Abdomina Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Month Pregnant at time of death Dav 2 No as been signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page performed' 2 No 1 Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examine? Yes Hospital 2 🗌 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2122 South Hanove Street Baltimore State 32. Registrar's Sig Registrar

DHMH 17 Rev 7/2009

amend items 6-9 per fh 2913 3-31-11 yr State of Maryland 7 Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1/INS 3:28 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional dure Prince George's Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 14, Birthplace (State or Foreign Country) Age (In vrs. last birthday) Hours 1 M 2 X F Director MD 58 If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han matter and 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc 1 Never Married 2 ☐ Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Donation 5 D Other (Specify) Signature of Funeral Service License D Balto., 2700 Edmondson Ave. art 1. Enter-the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a nonsecuence of that the death certificate be executed To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 2 No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🔀 No Be 26. Place of Death (Check only one) ျှ 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Accident Suicide Investigation within 24 hours after deat To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Sargine Brutus, MD Regional Hospital, Emergency Laurel Laurel 31. Date filed (Month Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			S	State of Maryland / Department		-	
		•	1 - For State Registrar		artificate of Death	Reg.	
	Dharinia	/	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
يستر	Physicia Medic		Carole Just			March	Day Year 8:30 KM
-	Examin	er	4a. Facility Name (if not institution, give stree		4b. City, Town, or Location of Death		4c. County of Death Calthore City
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 12 - 8 -	g Birthplace (State or Foreign
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	/anylan 8a-f sh tifled a	recto	MD Tob. County	10c. City, Town or Low BACT I			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ith the N 3a or 2 t be no	Funeral Director	10e. Street and Number 1010 Abbott Cou.	OT	10f. Zip Code 21202		Citizen of What Country?
	eath w	-une	11. Marital Status 12. \	Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Spe	cifv Yes or No-	14. Race - American Indian,
9800	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	by	1 Never Married 2 Married	1 Yes 2 No	f Yes, specify Cuban, Mexican, Puerto □ Yes 2 X No Specify:	Rican, etc.)	Black, White, etc. Specify: BLACK
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212	within rgiene.	Çor	Elementary/Seconday (0-12)		CHER AIDE		Education
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last) JESSE Cosby			(First, Middle, Maide Booth	en Surname)
Mar	2 should Ith and Me 27 is mar traumati		19a. Informant's Name/Relationship (Type, P IONYA DAVIS (DAU		ng Address (Street and Number or Rura PLYMOUTH Rd •		
ore,	of Hea of Hea fitem	- 1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem.	20b. Place of Dispo	sition (Name of	ate 20c.	Location - City or Town, State
ţ	t. Page 1 rtment of rtant: If it		4 ☐ Donation 5 ☐ Other (Specify)	CRESTLA	WN 3/19	/2011 MA	RLIOTBVILLE, MD
Ba	permit. F Departm Importal any injui		21. Signa fre of Funeral Service Licensee	7/553	Name and Address of Facility VAL 1905 YoRK RJ. B	AGHN GKE ALTIMOR	ENE FUNERAL SCUS E. MD · 21212
e e e e e e e e e e e e e e e e e e e	husician/ Medical Examiner	ıer	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate the conditions.	use on each line.	bit the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death
09/	ath certificate be executed attending physician and for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last d				
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the		in the past 12 months?	If yes, outcome of pregnancy	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ls, P.O	uires that t n signed b ild be deta	ا ۾	Part II. Other significant conditions contribu	uting to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Secord	he law req te has bee age 2 shoບ	Completed				24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
<u>a</u>	sian: T ertifica ctor, p		25. Was case referred to medical examiner?		26. Place of Death (Check		No 1 Yes 2 LA No
₹	Physic this ce al dire	욘	1 ☐ Yes 2 XNo	ital: 1			6 Other (Specify)
o uc	nding ath. : After e funer	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28c. Injury at work? M 1 □ Yes 2 □ No	8d. Describe how inj	ury occurred
Division	al or Atter s after des Il Director ed in by th	Certificate:	3 Suicide 6 Could not be	8e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	Hospite 24 hours Funera eted fille	Medical	(Check 2 L Medical Examiner: O	To the best of my knowledge, death o	igation, in my opinion, death occurred at	the time, date and place	ce, and due to the cause(s) and manner stated.
	To the within To the compl		only one) 3 Li Certifying Nurse Pra	actioner: To the best of my knowledge, d	29c. License number	29d. [Date signed (Month, Day, Year)
	V .		MASTIN	1.0.	065776	, Ma	rch 14,2011
	MV		30. Name and address of person who completed the second se	eted cause of death (Item 23a) (Type, Pr	rint) E. Eager J	treet	rch 14,2011 Baltimore mo 21202
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's Synature	J		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2<u>011</u> Physician/ March 12 12:00 P M Betty L. Connor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5209 Shelbourne Road Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1719726 Director 213-20-0412 85 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "hours" any injury or other transmit. 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🔀 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5209 Shelbourne Road 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Edward Lockard Carolyn Lindauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Kinsey / Daughter Sourwood Court Millersville, Md. 21108 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery : 3/17/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 est 23a. Part 1. Enter the disease, or shock, or heart failure. List on mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on sach line. terval Between Oper and Death Immediate Cause (Final Hunoris Physician/ disease or condition Medical resulting in death) (or as a consequence of): Examiner eventic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year signed by the at Id be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 24 hours after death.

Funeral Director: After this certificate 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 Tes 2 V No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number address of person who completed cause of death (Item, 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mou

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day : 16 PM Physician/ WILLIE DICKENS -ebr 20 Medical 4c. County of Death
PRINCE GEORGE'S 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** LANHAM DOCTORS HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** SEPT 22 1955 Min. Days Hours Months NORTH CAROLINA 577-74-0664 55 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. notified at Director 1 X Yes 2 No 28a-f MD PRINCE GEORGE'S BOWIE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ems 23a or r must be r ō Funeral USA 20716 15607 EVERGLADE LANE er than "natural", or items the Medical Examiner mus 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 □X/es 2 □ NoARMY Black, White, etc. à 1 X Never Married 2 ☐ Married Maryland 21215-0036 BLACK 1 ☐ Yes 2 🖾No If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 12TH Elementary/Seconday (0-12) GOVERNMENT PRINTER n and Mental Hygier 7 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ELLA DICKENS RICHARD ARCHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15607 EVERGLADE LANE BOWIE, MARYLAND 20716 ELLA WILLIAM/SISTER Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Donation 5 Onto Other (Specify) RIVERDALE CREMATORY RIVERDALE, MARYLAND 3/12/2011 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. ervice Licensee Signature of Funer 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Month Pregnant at time of death Yes g | Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and litle of certified 710 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOS Doctors eyene Communi 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

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ayvon D. Dods		State of Maryland / Department of He I-For State Certificate of De Registrar			2011 g. No.	084/1						
Physicia edical Examir	n/	Decedent's Name (First, Middle, Last)		2. Date of Death Month March 7, 2	Dav Year	3. Time of Death 1717 hrs						
edical Examin		TRAYVON D. DODSON 4a. Facility Name (if not institution, give street and number) 4b. C	ity, Town, or Location of Dea		4c. County of Death							
		Prince Georges Hospital Center Cheverly Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYY) 9. If Under 24Hrs. 1. Date of Birth (MM/DD/YYYY) 1. Date of Birth (MM/DD/YYYYY) 1. Date of Birth (MM/DD/YYYYY) 1. Date of Birth (MM/DD/YYYYY) 1. Date of										
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ith the 23a or	a	6505 HANSFORD STREET 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	20747 cedent of Hispanic Origin? (JSA 14. Race - Ameri	can Indian, Black,						
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director		pecify Cuban, Mexican, Puer		White, etc.							
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036 ithin 73 ne.	Completed by	12th NONE			NONE							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)	18.Mother's Nar VERA C	ne (First, Middle, N	laiden Surname)							
2121 Juld be f Mental Marke	To Be	HOWARD DODSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	VERA Codress (Street and Number of		ber, City or Town, State	, Zip Code)						
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or Heal		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition crematory or other p	lace)	Date	20c. Location - City or							
Baltimore, sermit. Pages I an Department of Hea Important: If iten miny or other transming or other transmin		4 Donation 5 Other Specify. CEDAR HILL 21. Signature of Funeral Service Licensee 22. Name		1 /2011 . B. JEN	SUITLAND, M	IARYLAND						
Ball Permi Depar Lings		Quane J. Callewa 7474	LANDOVER ROA	D HYATTS	VILLE, MARYI	AND 20785						
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buri		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	<u> </u>						
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Division tal or Attendi rs after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	actory, office building, etc.	28f. Location (S or Town, S		ural Route Number, City						
Divisi Hospital or At 24 hours after d Funeral Direct	5	4 Homicide determined (Specify) Local Street		1809 Ray Leo	nard Road, Landove	-						
To the Hos within 24 h To the Fur completely	Medical	Check only Medical Examiner: On the basis of examination and/or investigation, and manner stated.										
F.248	Me	29b/Signature and title of certifier	29c. License number		29d. Date signed (Mo	onth, Day, Year)						
		/ / Jahrells)	O.C.M.E.		March 8, 2011							
		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltir	more Street, Baltimore	, MD 21223								
St Regist	ate rar	31. Date filed (Month, Day, Year) 37 Agistrar's Signature	7									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY ,15,17&19a Per ANA BD 6933 11/27/2012 JH State of Maryland Department of Health and Mental Hygrene 11 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Peter Angelo De Arcangelis 2011 **Physician** 10 12:50A M March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cumber land Allegany 404 Park St. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 17 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 90 1 🖾 M 2 🗆 F Feb 21, 1921 Maryland 220-10-0838 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Perford Examinating and the problem of the prob 1 ☐ Yes 2 ☑ No Director Cumberland MT Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 404 Park St; PO Box 731 Funeral 12. Was Decedent Ever In U.S. Armed Forces?

125 Yes 2 No 1942 - If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: \$ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) transportation railroad -unk -unk-12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) De Arcangelis 12 should be fine hand Mental Fine marked otle Be Clementina Carpenti Domenico Antonio Dearcangelia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur Peter Mark De Arcangelis 801 Linda Ln; Charlotte, North Carolina 28211 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S. rv o 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Meta Immediate Cause (Fin Greinoma Zweeks Physician 5141 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day detached for 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown signed by of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ဩNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 N completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 240 1 Depatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

ne and address of person who completed cau

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31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MARCH 8-15 PM 13 011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Frederick Villa Nursing Home Catonsville Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Days (Month, Day Year) Hours Min 81 Oct. 1929 Maryland Director 218-26-2034 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 No Baltimore Baltimore 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 USA 1816 Summit Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Electric Co. 12 Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julia Siehlecka Michael J Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Francis Avenue, Halethorpe, MD 21227 Terry Hansen-Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Mar.17,2011 Dundalk Maryland Stanislaus Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signature of Fineral Service Licensee 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. OK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) has been signed by the attending physician and e 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 **N**No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I March 11, 2011 121649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILKENS AVE BALTIMORE, MD 21229 SAMBANDAM RAN 3455 31. Date filed (Month, Day, Year) 32. Registrar's Registrar

DHMH 17 Rev 7/2009

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Howard Dawson

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ID 21215-00; should be filed within and Mental Hygener. 7 is marked other it natic event, the Mes		19a. Informant's Name/Relations			19b.	Mailing .	Address (Street	t and Num	ber or Rur	ral Route Nu	mber, C	City or Town	n, State,	Zip Code)
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Baltimore, Moemit. Pages I and 2 Department of Health (mportant: If item 2 mjury or other traum)		4 Donation 5 Other S	_	G	reeni	Moun	erplace) T Gemai	tory	2/2	1/20/1		STUI	M 0 K	-6,1	νι <i>)</i>
Baltime permit. Pag Department Important: Injury or ot	Ī	21. Signature of Fun ral S ice				22. Na	me and Address	of Facility	VAU	SHN G	EE	NE F	חתנ	第 /程_ 5	CVS
	1	23a. Part I. Enter the disease, or	20155		ath Do not	144	05 YOR	K K	DMD ·	13AU	Test sh	ock or hea	212.		mate Interval
Physician /Medical	ľ	failure. List only one cause	e on each line.											Betwee	n Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as			rosc	lerotic	card	iovas	scular	di	sease	-		
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i i		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequenc	e of):										
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Box 687 c death certifi the attending ed for use as hysician	5	past 12 months?	4 Preg	nant at time of	2 fdeath 5		er (Specify)			,					
). Box 68' the death certification by the attending sched for use as	2		lknown 9 Unkr			_				Tan Bill					of death?
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aw rea ras be 2 shou	2									auto			rior to c eath?	ompletion	of cause of
Records, P.C. The law requires that ficate has been signed it, page 2 should be dear	3	· · · · · · · · · · · · · · · · · · ·								1 Yes	2 I	No 1	√ Ye	s	2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that this stafer death. Tal Director: After this certificate has been signed by lled in by the funeral director, page 2 should be detacled in by the funeral director.	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	✓ ER/Ou	tnatient		Other	(Check on	Home 5	Resid	lence 6	Other		
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ath.	5	1 X Natural 5 Pen	iding	h, Day,Year)			1 _ Y	res 2	No						
vision Attornation of the definition of the defi	3		estigation 28e. Pla	ce of Injury - A	At home, fai	rm, street	, factory, office b	uilding, et	c. 2	8f. Location or Town,		and Number	er or Ru	ral Route	Number, City
Division or spiral or Attending hours after death. meral Director: After filled in by the fune.		4 Homicide dete	ermined (Specify)						or rown,	State/				
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as a medical Certification: To Be Commisted by Physician.			Physician: To the be aminer: On the basis	of examination)
To Take To	퇃	29b. Signature and title of certific	and manner er	stated			29c. License	e number			29d.	. Date sign	ed (Mor	oth, Day, Y	'ear)
		-//	21. N	a -	TA		O.C.I	M.E.	OCME		Ма	rch 9, 20	011		
	F	30. Name and address of persor	n Who completed cau	se of death (I	tem 23a)	mi	Θ_{r}								n n
X		Theodore M. King, Jr.		ant Medica		ner 9	00 W. Baltim	nore Str	eet, Bal	timore, M	ID 21	223			
Stat Registra		31. Date filed (Month, Day, Year)	2011 32.	egtsmac's Sign	nature	1	el 0								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 16 Marv Elizabeth Fleece March 2011 p^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Home of Columbia Columbia Howard Social Security Number 8. Date of Birth Sep. 7, 1913 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours Min. 1 🗆 M 2 💢 F 97 304-09-4395 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified Direct Marvland Howard Columbia 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6280 Golden Hook Road 21044 United States or items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Pennsvlvania and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph H. Craig Eva Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Richard Fleece / Son 6280 Golden Hook Rd., Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 103/17/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ${
m Alyson}~{
m K}$ 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 No Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has the Hospital or Attending Physician: The Inin 24 hours after death.

the Funeral Director: After this certificate hapleted filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Hospital 2 🔀 No Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes Accident 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47447 March 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Lakers, 6334 Cedar Lane Suite 103, Columbia, Maryland 21044 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 20 Î Î 8:00 Рм Jessie Alice Farren Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Silver Spring Renaissance Gardens If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 93 Days Hours Min. March I, 1918 119-26-1262 1 🗆 M 2 😾 F Virginia Director Usual Residence of Decedent 28a-f shor 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 K No Prince Georges Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20705 USA 11202 Cherry Hill Rd. items ? death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. "natural", or \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Specify: White 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 | h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) nursing healthcare unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jessie Florence Dodson George Henry Thomas injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is 12406 Macao Ct; Herndon, Virginia 22071 Barbara Tighe - daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1 Approximate Interval Between Onset and Death shock, otheart failure. List only one cause on each line. Immediate Cause (Final Physician Advanced Dementia unknown disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Number Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page performed? After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Eileen Gemmell 3160 Gracefield Rd; Silver Spring, MD 20964

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RISBIdo"

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Teresa C. Freburger March 12, Day 2011 7:10 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A5442 Channing Road Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Nov. 18 ^{Year)}19<u>11</u> 215-14-9993 99 Yrs Maryland **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD N/ABaltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 United States 5442 Channing Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White Specify: Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Westinghouse Office Worker is marked other Be and 2 should be filed Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ May C. McGrath Joseph Gaskin traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3620 Greenvale Rd., Baltimore, MD 21229 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Joan M. Little - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) New Cathedral Cemetery 3-16-2011 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death -h, sici_n ebill disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Due to (or as a consequence oi): Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy performed 1 ☐ Yes 2 ☑ No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3/14/11 D43725 30. Name and address of person who completed cause of death (Item 23a) (Type Print) MD ge Road Nestminstr ALTMOUD 21157 TARIG 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08478 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kathleen Ann Freidly a M 15, March 2011 4:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Memorial Hospital Harve de grace Harford If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 □ ★ 215-68-5018 56 Director 06/29/1954 NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Madical Examination is ust be rediffed at MD Harford Aberdeen Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Market Street, Apt. 1 21001 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 🙀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Buren Parks Jr. Shirley Ann Kelly Booth or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Daniel N/ Freidly / Son 1433 Golden Rod Court, Belcamp, MD 21017 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 【Cremation 3 ☐ Removal from State 3/18/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD21203 21. Signature of Funeral Service Licensee Dorota Marshall Markall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Advanced **Physician** Chronic Obstructive disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ulmonar Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, discase 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s autopsy certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Provithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler (Check only one) 29b. Signature and title of certifier 29c, License number 29d, Date signed (Month, Dav. Year) D71096 MD

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANGELITA ESTADILLA 501 J. Union Haure de Grace, MD 21078

ORIGINAL

DHMH 17 Rev 1/2001

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantines must be notified at

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division of Vital Records,

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed the burial-tran page 2 should this After To the Hospital or Attent within 24 hours after death To the Funeral Director: filled in by

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Year :15 AM SYLVIA FRUCHTBAUM 2011 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🗓 F 07/06/1915 95 220**-**46**-**3794 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No **Funeral Director** MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8808 MARGATE COURT 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2XINo Specify: Be Completed by WHITE 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HARRY ROSEN ၉ REBECCA ACKERMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8808 MARGATE COURT, BALTIMORE, MD MARSHA ALVAREZ/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/16/2011 4 Donation 5 ☐ Other (Specify) BETH JACOB CEMETERY FINKSBURG, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia disease or condition resulting in death) Due to (or as a consequence of): zheimer Sequentially list conditions, if any, leading to inimisurate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 🗆 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed oduse of death (Item 23a) (Type, Print) Rd, Ellicott city, MD Sa 3621 azar 31. Date filed (Month, Day, Registrar's Signature Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2011 Physician/ March 11 Dominic Α. Folcarelli 1:05 рм Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Dulaney Vally Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept 14, 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 D F Min. 215-14-0792 1921 Maryland 89 **Director** Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 22a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County the Maryland Director 10c, City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 323 Wessling Circle 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give TA 1 Yes 2x No Specify: Specify: White Completed 3 - Widowed 4 - Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 5+College (1-4 or 5+) Elementary/Seconday (0-12) Management Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reginaldo Folcarelli Gwendalina Petrilli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Daniels (Daughter) 10113 Bracken Dr., Ellicott City, MD. 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Cremarby Loudon Park 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/14/11 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LYMPHOMA **Vedical** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 Yes 2 No 1 ☐ Yes 2 X No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 🗆 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

State Registrar

FOLCARELL!

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

JONES

JACKIE

2011

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 AM Thonu Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 □ F Days Hours May 25, Year 954 56 219-82-7283 Washington, D.C. Director Usual Residence of Decedent fshow 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified District of Columbia Washington 1 X Yes 2 No 23a or 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6627 - 1st Street, N. W. 20012 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ō þ Yes Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Completed Year or Dates ntal Hygiene. ked other than "natura event, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M one. Elementary/Seconday (0-12) College (1-4 or 5+) None None None Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Johnson **Delores** Gooda11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Goodall (Mother) 6210 Belcrest Road; Apt. 1223; Hyattsville, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) March 10,2011 Washington, D. C. Calenwood Cemetery gnature of Fu and Service 2. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence on Exami or Attending Physician: The law requires that the death certificate be executed the bunal-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed? X 1 Yes 2 No Yes 2 No s after death.

I Director: After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: <u>6</u> 2 🗶 No Other: 1 Tes 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Earlene Goodson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A **Examiner** 4b_City, Town, or Location of Death 1ary/and Stimore STENERAL 5. Social Security Number 8 Date of Birth If Under 1 Year | If Under last birthday) 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. ountry) 217-40-0969 1 M 2 TXF 68 Months Days Hours Min JuMoyn, 02/4/ear/1942 Director Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City Town or Location Baltimore Director 10d. Inside City Limits MD N/A 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 Madison Ave. Completed by Funeral 21205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black. White, etc 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 X Widowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland General Hosp. Elementary/Seconday (0-12) College (1-4 or 5+) OR Technitian 11th N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herman Baker Edith Smith 19a. Informant's Name/Relationship (Type, Print)
Yolanda White/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1507 Honeysuckle Ln Round Rock, TX 7866 4 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parkwood Cem 1 Surial 2 Cremation 3 Removal from State 3/22/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityBeverly 2700 Edmondson Ave. Signature of Funeral Service Licenses D. Cromartie F/S Balto., MD 21223 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final etha Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 🗌 Yes 2 🗎 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A' 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practices and the control of the basis of examination and/or investigation, in my opinion and the control of the basis of examination and/or investigation, in my opinion at the time of the cause(s) and the control of the basis of examination and/or investigation, in my opinion and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and/or investigation and the control of the basis of examination and or investigation and the control of the basis of examination and or investigation and the control of the basis of examination and or investigation and the control of the basis of examination and or investigation and the control of the basis of examination and or investigation and the control of the basis of examination and or investigation and the basis of examination and or investigation and the basis of examination and or investigation and the basis of examination and or investigation a (Check 29b. Signature and title of continer 29c. License number 29d. Date signed (Month, Day, Year) 3/14/201 00 6 3086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day, Year)

MAR 17

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examine	_	,	, 5	give street and number)	~			r Location of Death te Marsh	1		ounty of Deat	e County		
Funeral		5. Social Security No	umber 6	sted Livin		ast birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birt	thplace (State or Foreign		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Durial 2 4 Donation		B ☐ Removal from State	0	emetery, cri	oosition (Name of ematory or other place c Cremato		Date 5/2011		tion - City or Burni			
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Physic this ceral dire	2	1 Yes 2	No h	Hospital: 1 !npa 28a. Date of inj		ER/Outpati	ent 3 DOA Oth	4 Nursing H	lome 5 Resid			cify)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exami	lcare	1 Natural 2 Accident	5 Pending Investiga	(Month, Di		injury	work		28d. Describe I	28d. Describe how injury occurred				
		3 ☐ Suicide 4 ☐ Homicide	6 Could no determine		jury - At ho tc. <i>(Specify</i>	ome, farm, s	treet, factory, office		Street and N n, State)	reet and Number or Rural Route Number, , State)				
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101/	+	30. Name and addre	ess of person wh	ho completed cause of	death (Item	23a) (Type		38150		2	1011	1120		
100		Philips	12 g	aheen	670	IN.	Chee les.	St. Sw	te 410.	8,2	alte	all July		
State Registrar		31. Date filed (Mont	MAR 17	2011 32. Regist	rar's Signat	d.	barkel					-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month MANUEL MARTINEZ GONZALEZ 20 AM Medical 4a Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore TOWSON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours SPAIN 1 📉M 2 🗆 F JULY Day Z 171-52-0732 °,1928 82 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE MDTIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 DULANEY VALLEY ROAD 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 X Never Married 2 Married ¹X Yes 2 □ No Specify: SPANISH Baltimore, Maryland 21215-0036 If Yes, Give 3 Divorced Specify: WHITE Year or Dates d Mental Hygiene. marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **BROTHER** CATHOLIC CHURCH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ MANUEL MARTINEZ GONZALEZ CARMEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 FR. GERARD SZYMKOWIAK/CONFRERE 2300 DULANEY VALLEY RD., TIMONIUM, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOST HOLY REDEEMER 3/22/11 PHILADELPHIA, PA 21. Signature of Fun TLLY & ZEILER INC. FUNERAL HOME 00 S. CONKLING STREET, BALTIMORE 700 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Interval Between Onset and Death Immediate Cause (Final Prysician/ disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a construence of): the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 9 Unknown Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 X No 2 No 1 Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 🗌 Yes ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature an 29c. License number 254 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02th 20-2011 MARGARET VERONICA JOHNSON GASKINS 7:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Hospital Center Prince George's Chever1y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 1 □ M 2 🗓 F 08100 3ax 1809 22 88 DC 22 2928 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4403 Dix Street, NΕ 20019 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 🔽 Widowed 4 🗆 Divorced Specify: Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Robert Howard Johnson, Amy Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tran Robbie Cooke/Daughter 5707 Shawnee Dr., Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Riverdale Pk. Crem 2-24-2011 Riverdale, MD 1 Burial 2 KCremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 20746 Cedar Hill FH,4111 PA Ave., Suitland, MD 23a. Part 1 Enter the disease that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Interval Retween Onset and Death Immediate Cause (Final Physician/ trany ATAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner eaquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and I-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛣 No **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 ☐ Inpatient 2 🏋 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 063688 22,2011 Cheverly MD completed cause of death (Item 23a) (Type, Print) Name and address of person 3001 HOSPITAL HAVIS 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G913 3/21/2011 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar 08486 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James **Alexander** Hicks 2011 2230 hrs M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges 925 Lakefront Drive Mitchellville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Days Hours July 29,1931 578-42-9364 79 Yrs. Washington, D.C. Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location death with the Maryland ms 23a or 28a-f sho must be notified at 10a. State 10d. Inside City Limits Director Mitchellville 1 X Yes 2 No Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20721 United States 925 Lakefront Drive items 12. Was Decedent Ever in U.S.
Armed Forces IJS Marine
1 Ares 2 J No
1 Yes, Give March 1952
Year or Dates. March 1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. þ 1 Never Married 2 X Married ō Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U. S. Dept. of Air Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Audiovisual Information Specialist Force vears permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important; if item 27 is marked other tany injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Peter Alexander Hicks Mary Regina Diggs 9a, Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 Lakefront Drive; Mitchellville, Maryland 20721 Mattasie Louise Rembert Hicks 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cheltenham, March 11 cemetery, crematory or other place) 4 Donation 5 Other (Specify) Maryland Cheltenham Veterans Cemetery Maryland ignatur, of Pineral Service Lo Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2 yrs Death Immediate Cause (Final Ph. sician/ Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cerebrovascular Accident 2 yrs Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): 2 yrs or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Coronary Artery Disease and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical 15 yrs Systemic Hypertension Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypercholesterolemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🛚 No Hospital: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Naturai 5 Pending injury s after death. 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) INTERNAL MEDICINE NU Chanble 10, 2011 March D 00 637 49 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane Nita V. Shanbhag, M.D. Largo, Maryland 31. Date filed (Month, Day, Year) State barked MAR 17 Registrar

11-01956 Robert Charles Harding Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Consideration Consideratio			1- For State Registrar	Certificate of	Death	Reg. I	No.					
12014 Coloran Catalowy, Room 30 Coloran City Trust Yes Under Select No. One of Processor 17 Age (is yes, last similarly) Trust Yes Under Select No. One of Processor 18 Sold Security Muster 217-70-7249 (it) is " yes	an/	1. Decedent's Name (First, Middle,Last) Robert Charles Harding			Month Da March 12, 20	011	0820 hrs					
217-70-7249				4	Ocean City		Worcester					
The Sales Top County Top Co			017 70 70/0		Months Days Hours		MM/DD/YYYY) 9. B 1958 Fore C	irthplace (State or ign ountry)Mary1and				
March State Part Part Part Medical Lating Part Part Part Medical Lating Part	*	tor	10a. State 10b. County 10c. Delaware Sussex	City, Town or Location	Frankfor		Citizen of What Co	1 Yes 2 No				
1	the Mary a or 28a- tified at					1						
Survey Technician Land Surveying L	fter death with I", nr items 23 ier must be no	<u>" </u>	1 Never Married 2 Married Armed Forces? 1 Yes 2	White, etc.								
21. Signature of Funeral Service Licenses Al YSON K Taylor 22. Mare and Address of Facility Cremation Society of Maryland 21.228 12. Signature of Funeral Service Licenses on completions that caused the death. Do not enter the mode of dying, such as addition or respiratory arrest, shock, or heart Approximate interval Selveen-Conditions Alcohol and Oxycodone Intoxication Approximate interval Selveen-Conditions Alcohol and Oxycodone Intoxication Approximate interval Selveen-Condition resulting in death) Amendment of the cause of condition resulting in death) Amendment of the cause of conditions Alcohol and Oxycodone Intoxication Approximate interval Selveen-Conditions Alcohol and Oxycodone Intoxication Due to (or as a consequence of): Due to (o	hin 72 hours a' e. than "natural edical Examin		Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	ost of working life. DO NOT	use retired)						
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21. Signature of funeral Service Liberises Alyson K Taylor 22. Name and Address of Facility Crematicion Society of Maryland 21.228 22. Signature of funeral service Liberises or completions that caused the death. Do not enter the mode of dying, such as cardinator respiratory arrest, shock, or heart and produced for the failure. List only one cause on each line. Alcohol and Oxycodone Intoxication 23. Part I. Fert me disease, or completions that caused the death. Do not enter the mode of dying, such as cardinator respiratory arrest, shock, or heart and between forester and forester a	MD 61.	10		11317	Rawhide Rd.	, Lusby, Mar	yland 206	57				
23a. Part Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allowed closed and followed the followed contribute to the cause or death?	IIMOre, Pages I and ment of Heal rant: If item		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	Metro Cre	ematory Inc.	03/17/2011	Baltimore	, Maryland				
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Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a	/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Alcohol at	nd Oxycodo			shock, or heart	Between Onset and				
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past 12 months? Type 2 No 9 Unknown	executed ian and ial - trans	_ 1	d. IN UNPENDED AMENDED 23a, 2	27,28a-f p	er me g914 4-	-22-11 vt						
1 Yes 2 No 3 Probably 4 Unknown	certif nding		23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time	2 Fet		pregnancy		•				
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 28. Date of Injury 28. Place of Death (Check only one) 28. Doad 28. Date of Injury 28. Date of Injur	s that the d gned by the e detached	ā	1 Yes 2 ✓ No 3 Pro									
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 28. Date of Injury 28. Place of Death (Check only one) 28. Doad 28. Date of Injury 28. Date of Injur	(ecords, The law require ate has been si age 2 should b	ompleted	prior to ed? death?	completion of cause of								
Natural 5 Pending Investigation 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)	sician: sician: is certifi lirector,	Be	examiner? Hospital: 4 Innations	2 ER/Outpatient	Tai	`	sidence 6 🗸 Oth	er: Scene				
Security 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) Fd. 3-12-1		njury 28c. Injury at Work	? 28d. Describe how		· · · · · · · · · · · · · · · · · · ·				
O.C.M.E. March 13, 2011 30. Name and address of person who completed cause of death (Item 23a)	Spital or Att spital or Att nours after de neral Direct filled in by		28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 4 Homicide Homicide Homicide Homicide Science According to the street of the street									
O.C.M.E. March 13, 2011 30. Name and address of person who completed cause of death (Item 23a)	n the Ho ithin 24 l o the Fu ompletely	dical	one) 2 Medical Examiner: On the basis of examinar	wledge, death occurr tion and/or investigat	red at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause(s curred at the time, date and	s) and manner as sta d place, and due to	ated. the cause(s)				
30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		Me	29b. Signature and title of certifier									
	Mary				ann Straat Baltimara	MD 21201						

11-02054 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kenneth Holtman State of Maryland / Department of Health and Mental Hygiene 2011 08488 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day March 15, 2011 **Medical Examiner** Kenneth Wayne Holtman 2345 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Director Davs Hours 215-90-3378 Country) Mary Land 1 X M 2 F Dec.15,2011 47 Usual Residence of Decedent 10b. Count Oc. City, Town or Location 10d Inside City Limits s 23a or 28a-f show e notified at once. Maryland Anne Arundel Glen Burnie 1 Yes 2 X No with the Maryland 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? 800 Castle Road 21061 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Specify: White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 2 Pages 1 and 2 should be filed within 72 hours a nent of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than " r traumatic event, the Medical Home Improvement 10 Construction Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Walter Edward Holtman, Sr. Shirley Mae Warndoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Holtman 1449 Medfield Road, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation, Inc. 3-17-11 Hanover, Maryland 4 Donation 5 Other Specify. 21. Signature of Funeral Service License 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Marylan 23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 6009Harford Road,Baltimore,Maryland 21214 Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Narcotic(Heroin) Intoxication Immediate Cause (Final disease ≛xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): ovents resulting in death) Last attending physician and for use as the burial - transit Division of Vital Records, P.O. Box 68760, edical AMENDED 23a, 27, 28a-f per me g914 4-15-11 vt X UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery dent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autoosy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other Inpatient 2 FR/Outpatient 3 DOA 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Director: d in by the f within 24 hours after death.

To the Funeral Director: 1 Yes 2 X No fd 0:05pm fd 3-15-11 unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide 6 X Could not be or Town, State) 2206 Eagle St. Baltimore, Md. determined residence Homicide 29a, Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

OCMF 2006

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

gistrar's Signature

Zabiullah Ali, M.D.

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 16, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1502 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Hours Min. 09-03-Director Usual Residence of Decedent tr of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MDBALTIMORE 1X Yes 2 ☐ No 10g. Citizen of What Country? Completed by Funeral 913 Edge combe CIRCLE 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK 3 - Widowed 4 - Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE ECURITY GUARD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN ဂ KAREN HARRIS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 PINE HEIGHTS AVE. BALTO, MD 21229 StEFanie A. Beale SISTER permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

CREENMOUNT (REMATORY) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 Cremation 3 ☐ Removal from State BAUTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funoral Service Licensee 22. Name and Address of Facility GREENE CREMATION SERVICES S. STRICKER ST. BALTO, MO. 21223 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ barachnoid disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Year Month Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ u Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ 1 M Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide iniury 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🛮 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature and title of 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore GREENE St Lewis 22 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

ME/M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Smand 123a (a.P.t. JI per med sert G919, 9/20/11 dk Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2011 EDWARD A. HOLLIS March 12 /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A If Under 24 Hrs. a Birthplace (State or Foreign
Country) Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 XM 2 □ F Yrs. 2-18-1947 MARYLAND 215-46-8254 63 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be rollfied at 1 X Yes 2 □ No Director N/ABALTIMORE 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number 3120 MONDAWMIN AVE. 21216 USA filed within 72 hours after death Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) -12-BUS DRIVER TRANSPORTATION -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARION HOLLIS VIVIAN VINES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MURIEL HOLLIS (WIFE) 3120 MONDAWMIN AVE. BALTIMORE, MARYLAND 21216 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3-23-2011 Department of H Important: If ite any injury or ot once. 1 Durial 2 Deremation 3 Removal from State GARRISON FOREST VETERANS DWINGS MILLS, MARYLAND 4 Donation 5 ☐ Oyner (Specify) D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. 21. Signatu 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, si ock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease) Condition Approximate
Interval Between
Onset and Death
- 3 weeks hysician Shock secondary resulting in death) /Medical Due to (or es e consequence of): Examiner days Streptococcus agalactiae bactermia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by coronary artery disease, congestive heart failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should To the Hospital or Attending Physician: The law requivithin 24 hours after death.

To the Funeral Director: After this certificate has been chronic kidney disease, diabetes mellitus, hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Month Physician/ March 10, John Jaisle 1:00 AM Dona_{1d} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville National Lutheran Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** Days Sept 18, Year) 926 1 ▼ M 2 □ F Months Hours New York 077-20-6991 84 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10d. Inside City Limits 72 hours after death with the Maryland 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2X No Marvland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code Funeral 9701 Veirs Drive 20850 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14 Bace - American Indian. 11, Marital Status Armed Forces? Black, White, etc. ori à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 1947 Specify: White 3 Widowed 4 Divorced Year or Dates Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Repairman Communications æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alfred Jaisle Catherine Berta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Julia Jaisle (Wife) 9701 Veirs Dr., Rockville, MD 20850 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Patrick's Cemetery 03 - 14 - 11Bay Shore, NY ²² Narge and Address of Facility Frederick J. Chapey & Sons Funeral 1225 Montauk Hwy., West Islip, NY 21, Signature of Funcial Service License Inc. 23a. Part 1. Enter the disease, or complications that owised the death. Do not enter such as carding or respiratory arm Approximate Interval Betweer shock, or heart failure. List only one cause an ear Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last nding physician ause as the burial-Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the a 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ANO 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No this certificate Yes 2 4

0 4

24 hours after death.

Funeral Director: After the leted filled in by the funeral

within 2.

State Registrar

25. Was case referred to medical

5 Pending

and title of certifier

Charles W. Karesh, MD

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

examiner? 1 Yes 2 No

27. Manner Jeath

Natural Accident

4 Homicide

only one

31. Date filed (Month, Day, Year)

29a. Certifier

29h **≴**ignaty

Be

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Certificate:

Medical

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

iniury

28a. Date of injury (Month, Day, Year)

32. Rehistrar's Signature

26. Place of Death (Check only one)

2 🗌 No

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

26033 Ridge Road, Damascus, MD

work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioney. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nursing Home 5 Residence 6 Other (Specify)

City or Town, State)

20872

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Seasons Hospice Randallstown If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Min (Month, Day, Yea 10-11-1923 **Director** 212-22-8871 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2X No <u>Baltimore</u> Reisterstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 22 Bond Avenye USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2
If Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: African-American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Grason R. Johnson Sr. Naomi. Madden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna T. Johnson/Wife 22 Bond Avenue, Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. 3-19-2011 St. Lukes Cemetery Reisterstown, MD Donation 5 C Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. . Signatu 9200 Liberty Road, Randallstown, MD 21133 23a. Part/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death 18 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicial completed filled in by the funeral director, name 2 change has deather the attending physicial. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If <u>ye</u>s, outcome of <u>pr</u>egnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 MNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Deet Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Edward Vernon Jones, Jr.

2011 08493

		- For State	•	Ċer	tificate of L	Death		R	eg. No.	1 2	0047	
Physiciar ledical Examin	1/	I. Decedent's Name (First, Middle		Verno	n Jones, J			2. Date of Dea Month February	Day Ye 8, 2011	ar	3. Time of Death 0755 hrs	
	Í	4a. Facility Name (if not institution 6015 Griffith Drive		r Location of Deat Is			George's					
Funeral Director		5. Social Security Number 219 06 1324	6. Sex 7. A	Age (In yrs. Ia	ast birthday) Yrs.	Months Day		_	1979	Foreign Cour		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	1					10d. Inside City Limits	
* "	۱,	Maryland Prince	e George's		Suitland						1 Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 5704 Gloria	Drivo			10f. Zip Code 2074			0g. Citizen of W		ry?	
vith the	I	11. Marital Status	12. Was Decede	ent Ever in U.		Decedent of H	ispanic Origin? (S	pecify Yes or No		e - America	an Indian, Black,	
	Fune	1 Never Married 2 Ma	Armed Force 1 Yes Orced If Yes, Give Year	2 XX No			n, Mexican, Puert	o Rican, etc.)		Afric	an American	
nours a	o po	15. Decedent's Education (Spec					ation (Give kind of e. DO NOT use re		16b. Kind of B	usiness/In	dustry	
36 nin 72 l	ompleted	Elementary/Secondary (0-12)	College (1-4 o	or 5+)	Disabi	lity			N/A			
5-00 led with Hygien other	ပေ၂	17. Father's Name (First, Middle,					18.Mother's Nam	e (First, Middle,		э)		
D 21215-0036 should be filed within 72 hou and Mental Hygene. The marked other than "nath artie event, the Medical Exa	o Be	Edward Ve 19a. Informant's Name/Relationsl	ernon Jones, S	r.	19b. Mailing A	Address (Stre	Sha eet and Number or	<u>rron Jacqu</u> Rural Route Nu	eline Joh	n.son wn, State,	Zip Code)	
MD 2 od 2 shoul lith and N m 27 is m aumatic	Ĕ	Edward V. Jones, S			J.I.		ve, <u>Suitla</u>		746			
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Important: If item 27 is to injury or other transment.		20a. Method of Disposition 1 XX Burial 2 Cremation	3 Removal from	1	Place of Disposition of the Company		emetery,	Date	20c. Location	- City or T	own, State	
Baltimore, permit. Pages 1 ar pepartment of Her Important: If ite injury or other tr	-1	4 Donation 5 Other Sp	ecify:		urrection	Cemetery	Fe	b 12, 201	1 Clinton	_ MD_		
Balti permit. Departm Imports	ŀ	21 Signature of Funeral Savio	Man		I For	me and Addres	Clinton.	Funeral :	Home,Inc	5633 0	ld Alexandri	
Physician	\dashv	23a. Part I. Inter the Isease, or failure. List of one cause	complications that cause	ed the death.	. Do not enter the	mode of dying	g, such as cardiac	or respiratory an	rest, shock, or h	eart	Approximate Interva Between Onset and	
Wedical Examiner		Imme tate Cause Final disease	aAcute Alc	obol.	Intoxica	tion					Death	
		or condition resulting in death)	Due to (or as a cor b.	nsequence o	f):							
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence o	f):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence o	f):		-					
		X UNPENDED	d AMENDED ,,									
760, cate be exphysician	Medical	IF FEMALE:	#2 23c. If yes, outo	3a,27,	,28a-f,po nancy		13,3/23/		23d. Date	of delivery		
ox 687 ath certifica		23b. Was decedent pregnant in the past 12 months?	e 1 Live birth		2 Feta	I death 3 or (Specify)	Ectopic pregi	nancy	Month	Da	ay Year	
Box 687 e death certifit the attending the death certifite	Physician	1 Yes 2 No 9 Unk	nown 9 Unknown		5 Othe	у (Эреспу)			(41)			
hat the	D D	Part II. Other significant condit	ons contributing to de	eath but not r	esulting in the un	derlying cause	given in Part i.				he cause of death? ably 4 🗹 Unknown	
ords, P	ted			_				24a. Was	an 24b.	Were aut	opsy findings availab	
COFC law re has be									ormed?	death?	ompletion of cause of	
		25. Was case referred to medica				26.Pla	ce of Death (Chec	k only one)				
of Vital Sing Physician: After this certifi funeral director.	To Be	examiner? 1 ✓ Yes 2 No		atient 2	ER/Outpatient				Residence 6		Scene	
n of iding Pl h. there e funera		27. Manner of Death 1 Natural 5 Pend	(Month, Da	(Month, Day, Year) Fnd •							1cobol	
r Atter r Atter rer deat irector n by th	ficat	2 X Accident Investigation O2-08-2011 7:50 AM Subject 19									ral Route Number, Ci fith Driv	
Division pital or Attencours after death seral Director: filled in by the	S	4 Homicide dete	rmined (Specify)	Reside				uitlan	d,P.G.	Count	y, MD 207	
	Medical (29a. Certifier (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of e	examination a	lge, death occurre and/or investigation	ed at the time, on, in my opini	date and place, a on, death occurred	nd due to the cau I at the time, date	use(s) and mann e and place, and	er as state I due to the	ed e cause(s)	
To the I within 2 To the I complet	Med	29b. Signature and title of certifie	and manner state	and manner stated. 29c. License number								
		(Calorle	und			0.0	C.M.E.		February	9, 2011		
	Ì	30. Name and address of person Laron Locke MD. A	who completed cause of ssistant Medical E	of death (Iten	900 W. Bal	timore Stre	eet, Baltimore	MD 21223				

State Registrar

31. Date filed (Month, Day, Year) **MAR 1** 7 2011

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 1 4 Pay 03^{Month} Physician/ 1409 M 2011 Corlethia Denise Johnson Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince Georges Co Laurel 9447 Trevino Terrace 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Days 1 2972 34 4956 Maryland 1 M 2 😾 F 54 213-70-5980 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 Yes 2X No Laurel MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A. 20708 9447 Trevino Terrace death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 XNo 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 l and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Bowie State Univ. Legal Secretary vear Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ruth Young permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic traumatic Corley Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2078219a. Informant's Name/Relationship (Type, Print) 6710 Queens Chapel Rd., University PArk, MD Sharon Davis(sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Dremation 3 Removal from State on-site Crematory 03/18/11 Baltimore, MD 4 Donation 5 Other (Specify) Funeral Home PA Baltimore, MD21 21. Signature of Funeral Service License 22Josephdren of Fabitown Jr. MD21217 2140 N.Fulton Ave., laca on Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Complications ₽nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 s has 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examinara 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည funeral (28c. Injury at work?

__1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 5 Pending Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Col 31. Date filed (Month, Day, Year) **MAR 1** 7 **201** 32. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03-14-2011 1130 Р м John J. Kaufman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Perry Hall 9907 Forge Park Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country) MD 1 ፟፟፟ M 2 □ F Hours 09 - 13 - 1925 85 Director 219-18-3957 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Perry Hall 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21128 9907 Forge Park Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Small Business Advisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Marie Nau George Victor Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9907 Forge Park Rd Perry Hall MD 21128 Louise Kaufman (Wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 03-19-2011 Baltimore, MD Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Inc 9705 Belair Rd Nottingham MD 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ years disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has r this certificate h ral director, page 2 🗌 No Yes 2 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 7/2009

To the I within 2

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 upper Chesapeake Dr

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2011

Belair MD 21014

11-01954 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert David Kohlberg, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day March 12, 2011 Madical Examiner 0910 hrs Robert David Kohlberg Jr 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 3108 White Oak Drive Abinadon Harford 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. 8irthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director 369-96-3326 29 05 - 13 - 1981Country) Texas Yrs Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show Harford Abingdon tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at onec. within 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country 3108 WhiteOak Drive 21009 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nit. Pages I and 2 should be filed within ratment of Health and Mental Hygiene ortant: If item 27 is marked other than ty or other traumatic event, the Medical Pub 12 Bartender 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert D. Kohlberg Sr Laurie Ann Conner Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abingdon, MD 21009 Robert D. Kohlberg Sr (Father) 3108 WhiteOak Dr 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 03-17-2011 Baltimore, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility 21 Signature of Funeral Service Licensee Schimunek Funeral Home of BelAir Inc 610 W. MacPHail Rd BelAir, MD 21014 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician 1 4 1 failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease a Fentanyl And Clonazeram Intoxication ≟xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial • transit Physician/Medical 28a per me g914 4-27-11 vt UNPENDED X AMENDED #23a,27,28a-f,perME,G913,3/29/2011,WS Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has il director, page 2 sh performed death? 1 ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 Natural Subject Used Drugs 5 Pending 1 Yes 2 No I Director: Fnd: 9:02 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 3108 White Oak Driv determined (Specify) Homicide Found At Residence Abingdon, Marvland 29a. Certifier 1 Certifying Physician: T the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 13, 2011 30. Name and address of person who completed cause of rear (Item 23a) 8V Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08497 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ralph Wayne Physician/ Kolbe March 201[°]1° 6:05A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yo August29 5. Social Security Number 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Maryland 212-62-8474 57 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 28a-f Maryland Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 27 is marked other than "natural", or items 23a or rraumatic event, the Medical Examiner must be Funeral 8155 Kavanagh Road 21222 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 - Widowed 4 N Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Man Janitoral Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Rufus A. Kolbe Biddie L. Stockton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 532-B Allegheny Avenue, Towson, Maryland 21204 Franklin J. Kolbe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1
Burial 2
Cremation 3
Removal from State Ardent Cremation, Inc. 3-17-11 Hanover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel. P.A. muchael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician BLADDER CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consecuence cry is been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death 4 ☐ Pregnam a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe filled in by the funeral director, page 2 1 ☐ Yes 2 ☐ No After this certificate Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 1 Yes 2 X No မှ ER/Outpatient 3 DOA 1 Inpatient 2 Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: iniury 1 X Natural 5 Pending 1 \(\text{Yes} 2 🗌 No Accident Investigation s after deat Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7011 Jeanne Lantini /Medical 4c. County of Death 4b. City, Town, or Location of Death ame (If not institution, give street and number Examiner N/A ave Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min. Months Davs Hours 1 □ M 2 📉 69 Yrs. 220-76-3132 25 1941 April Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, II he Medical Examiner must be notified at 1XYes 2 □ No Director Baltimore Maryland Gwynn Oak 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1103 Sunny Court 21207 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No Never Married 2 Married 1 □Yes 2XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 10th grade Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Evans Frank Lantini ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anthony Lantini - BROTHER 18 Ridge Road, Catonsville, MD 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 03-16-2011 Metro Crematory INC. ^{22. Name and Address of Facility} Cremation Society Of Maryland INC 299 Frederick Road, Baltimore, MD 21228 f Funeral Service Licensee Patrik Fleming Kemer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between et and Death aus Immediate Cause (Final Septicem Physician disease or condition resulting in death) /Medical Due to (or as a contequence of): Examiner pidura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transi-Due to (or as a consequence of): しなかわか (Aしかん) Division of Vital Records, P.O. Box 68760, Cevelova Physician/Medical aftending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 mon 1 ☐ Yes 2 ☐ No 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🖼 📉 o 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death 1 HNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tonya

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20 FT 7:43 Рм Robert Wesley Lauber Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore If Under 24 Hrs. Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 446-18-2197 Months 1 ▼ M 2 □ F (Month, Day, Year) Director Oklahoma Dec Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location by Funeral Director 10d. Inside City Limits 1 Yes 2 X No MD Prince Georges Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20770 9-M Ridge Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Specify Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) analyst census bureau Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Leo A. Lauber Myrle Margaret Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9-M Ridge Rd; Greenbelt, Maryland 20770 Dorothy Lauber - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Ronald S Ward 22. Name and Address of Facility State Anatomy Board 21. Signato Director 655 W. Baltimore St; Baltimore, MD 21201 22 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, heart fallure. List only one cause on each line Interval Between Immediate Cause Final Onset and Death Physician/ Bladder IN KNOW N disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (of as a consequence of). attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months? Day Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) **Division of Vital** examiner? Hospital 4 Nursing Home 5 Residence 6 Nother (Specify) 2 Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending Accident М Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) amille Meninc her Hospice 31. Date filed (Month, Day, Year) State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ Lawrence Stuart Levin 14, Medical March 6:40 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Towson Baltimore 8. Date of Birth (Month, Day, Year) Tune 26, 1952 . Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 1 X M 2 □ F Months Days Hours **Director** 216-62-2642 58 Usual Residence of Decedent or 28a-f show e notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits PA York 1 Yes 2 No New Freedom 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be ms 23a must be Funeral 2 Still Pond Drive 17349 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or iten I Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 ☐ Yes 2 🕅 No If Yes, Give Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Divorced Specify: White Year or Dates or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) State of Maryland/ Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Public Safety Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Arnold Levin Hanna R. Fleischer 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Levin/Wife Still Pond Drive New Freedom, PA 17349 20b. Place of Disposition (Name of cemeter), crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State March 21. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2011 Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Michael J. Flagle 10 W. Padonia Road Timonium, MD Part 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, my one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Metastric small cell carring at small disease or condition Wecks Medical resulting in death) Due to (or as a consequence of). intestine Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Yes 2 No 9 Unknown g Unknown Part II**. Other significant conditions** contrib*u*ting to death but not resulting in the underlying ca*u*se given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WIPIL မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 1 Yes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my optimized data. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0 29d. Date signed (Month, Day, Year) MARCON 14 ZOIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /0√

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